IOWA ADMINISTRATIVE BULLETIN

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PUBLISHED UNDER AUTHORITY OF IOWA CODE SECTIONS 2B.5 AND 17A.6

PREFACE

The Iowa Administrative Bulletin is published biweekly in pamphlet form pursuant to Iowa Code chapters 2B and 17A and contains Notices of Intended Action and rules adopted by state agencies.

It also contains Proclamations and Executive Orders of the Governor which are general and permanent in nature; Regulatory Analyses; effective date delays and objections filed by the Administrative Rules Review Committee; Agenda for monthly Administrative Rules Review Committee meetings; and other materials deemed fitting and proper by the Administrative Rules Review Committee.

The Bulletin may also contain public funds interest rates [12C.6]; workers' compensation rate filings [515A.6(7)]; usury rates [535.2(3)"a"]; agricultural credit corporation maximum loan rates [535.12]; and regional banking—notice of application and hearing [524.1905(2)].

PLEASE NOTE: *Italics* indicate new material added to existing rules; ~~strike through letters~~ indicate deleted material.

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Iowa Administrative Bulletin

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All checks should be made payable to the Treasurer, State of Iowa. Send all inquiries and subscription orders to:

Attn: Stephanie Cox
Legislative Services Agency
Capitol Building
Des Moines, IA 50319
Telephone: (515)281-3568

Schedule for Rule Making
2004

NOTICE SUBMISSION DEADLINE	NOTICE PUB. DATE	HEARING OR COMMENTS 20 DAYS	FIRST POSSIBLE ADOPTION DATE 35 DAYS	ADOPTED FILING DEADLINE	ADOPTED PUB. DATE	FIRST POSSIBLE EFFECTIVE DATE	POSSIBLE EXPIRATION OF NOTICE 180 DAYS
Jan. 2 '04	Jan. 21 '04	Feb. 10 '04	Feb. 25 '04	Feb. 27 '04	Mar. 17 '04	Apr. 21 '04	July 19 '04
Jan. 16	Feb. 4	Feb. 24	Mar. 10	Mar. 12	Mar. 31	May 5	Aug. 2
Jan. 30	Feb. 18	Mar. 9	Mar. 24	Mar. 26	Apr. 14	May 19	Aug. 16
Feb. 13	Mar. 3	Mar. 23	Apr. 7	Apr. 9	Apr. 28	June 2	Aug. 30
Feb. 27	Mar. 17	Apr. 6	Apr. 21	Apr. 23	May 12	June 16	Sept. 13
Mar. 12	Mar. 31	Apr. 20	May 5	May 7	May 26	June 30	Sept. 27
Mar. 26	Apr. 14	May 4	May 19	May 21	June 9	July 14	Oct. 11
Apr. 9	Apr. 28	May 18	June 2	June 4	June 23	July 28	Oct. 25
Apr. 23	May 12	June 1	June 16	June 18	July 7	Aug. 11	Nov. 8
May 7	May 26	June 15	June 30	July 2	July 21	Aug. 25	Nov. 22
May 21	June 9	June 29	July 14	July 16	Aug. 4	Sept. 8	Dec. 6
June 4	June 23	July 13	July 28	July 30	Aug. 18	Sept. 22	Dec. 20
June 18	July 7	July 27	Aug. 11	Aug. 13	Sept. 1	Oct. 6	Jan. 3 '05
July 2	July 21	Aug. 10	Aug. 25	Aug. 27	Sept. 15	Oct. 20	Jan. 17 '05
July 16	Aug. 4	Aug. 24	Sept. 8	Sept. 10	Sept. 29	Nov. 3	Jan. 31 '05
July 30	Aug. 18	Sept. 7	Sept. 22	Sept. 24	Oct. 13	Nov. 17	Feb. 14 '05
Aug. 13	Sept. 1	Sept. 21	Oct. 6	Oct. 8	Oct. 27	Dec. 1	Feb. 28 '05
Aug. 27	Sept. 15	Oct. 5	Oct. 20	Oct. 22	Nov. 10	Dec. 15	Mar. 14 '05
Sept. 10	Sept. 29	Oct. 19	Nov. 3	Nov. 5	Nov. 24	Dec. 29	Mar. 28 '05
Sept. 24	Oct. 13	Nov. 2	Nov. 17	***Nov. 17***	Dec. 8	Jan. 12 '05	Apr. 11 '05
Oct. 8	Oct. 27	Nov. 16	Dec. 1	Dec. 3	Dec. 22	Jan. 26 '05	Apr. 25 '05
Oct. 22	Nov. 10	Nov. 30	Dec. 15	***Dec. 15***	Jan. 5 '05	Feb. 9 '05	May 9 '05
Nov. 5	Nov. 24	Dec. 14	Dec. 29	Dec. 31	Jan. 19 '05	Feb. 23 '05	May 23 '05
Nov. 17	Dec. 8	Dec. 28	Jan. 12 '05	Jan. 14 '05	Feb. 2 '05	Mar. 9 '05	June 6 '05
Dec. 3	Dec. 22	Jan. 11 '05	Jan. 26 '05	Jan. 28 '05	Feb. 16 '05	Mar. 23 '05	June 20 '05
Dec. 15	Jan. 5 '05	Jan. 25 '05	Feb. 9 '05	Feb. 11 '05	Mar. 2 '05	Apr. 6 '05	July 4 '05
Dec. 31	Jan. 19 '05	Feb. 8 '05	Feb. 23 '05	Feb. 25 '05	Mar. 16 '05	Apr. 20 '05	July 18 '05

PRINTING SCHEDULE FOR IAB

ISSUE NUMBER	SUBMISSION DEADLINE	ISSUE DATE
11	**Friday, November 5, 2004**	**November 24, 2004**
12	**Wednesday, November 17, 2004**	**December 8, 2004**
13	**Friday, December 3, 2004**	**December 22, 2004**

PLEASE NOTE:

Rules will not be accepted after **12 o'clock noon** on the Friday filing deadline days unless prior approval has been received from the Administrative Rules Coordinator's office.

If the filing deadline falls on a legal holiday, submissions made on the following Monday will be accepted.

*****Note change of filing deadline*****

PUBLICATION PROCEDURES

TO: Administrative Rules Coordinators and Text Processors of State Agencies
FROM: Kathleen K. West, Iowa Administrative Code Editor
SUBJECT: Publication of Rules in Iowa Administrative Bulletin

The Administrative Code Division uses QuickSilver XML Publisher, version 2.0.0, to publish the Iowa Administrative Bulletin and can import documents directly from most other word processing systems, including Microsoft Word, Word for Windows (Word 7 or earlier), and WordPerfect.

1. To facilitate the publication of rule-making documents, we request that you send your document(s) as an attachment(s) to an E-mail message, addressed to both of the following:

bruce.carr@legis.state.ia.us and
kathleen.west@legis.state.ia.us

2. Alternatively, you may send a PC-compatible diskette of the rule making. Please indicate on each diskette the following information: agency name, file name, format used for exporting, and chapter(s) amended. Diskettes may be delivered to the Administrative Code Division, Third Floor West, Ola Babcock Miller Building, or included with the documents submitted to the Governor's Administrative Rules Coordinator.

Please note that changes made prior to publication of the rule-making documents are reflected on the hard copy returned to agencies, but not on the diskettes; diskettes are returned unchanged.

Your cooperation helps us print the Bulletin more quickly and cost-effectively than was previously possible and is greatly appreciated.

The Administrative Rules Review Committee will hold its regular, statutory meeting on Tuesday, November 9, 2004, at 9 a.m. in Room 116, State Capitol, Des Moines, Iowa. The following rules will be reviewed:

ADMINISTRATIVE SERVICES DEPARTMENT[11]
Customer councils—term of membership, 10.1, 10.5(3), Filed Emergency **ARC 3751B** 10/27/04

ATTORNEY GENERAL[61]
Victim services grant program, ch 9 div III, 9.50 to 9.65, Notice **ARC 3725B** 10/13/04

CAPITAL INVESTMENT BOARD, IOWA[123]
Tax credits for investments in qualifying businesses, community-based seed capital funds and venture capital funds, 2.1 to 2.3, 2.5(2), 2.9, 3.1, Filed **ARC 3740B** 10/13/04

COLLEGE STUDENT AID COMMISSION[283]
EDUCATION DEPARTMENT[281]"umbrella"
Iowa tuition grant program, ch 12, Filed **ARC 3738B** 10/13/04
Approval of postsecondary schools, ch 21, Notice **ARC 3739B** 10/13/04
Student loan debt collection, ch 37, Filed **ARC 3737B** 10/13/04

CORRECTIONS DEPARTMENT[201]
Employees of judicial district department of correctional services—carrying of firearms, 40.1, 40.4(9) to 40.4(11), 40.4(12)"a" and "c" to "j," 40.5(3)"b," Notice **ARC 3726B** 10/13/04

ECONOMIC DEVELOPMENT, IOWA DEPARTMENT OF[261]
Housing fund—American dream down payment initiative, 25.4(4), Notice **ARC 3730B** 10/13/04

EDUCATIONAL EXAMINERS BOARD[282]
EDUCATION DEPARTMENT[281]"umbrella"
Special education consultant endorsement, 15.3(1), Filed **ARC 3732B** 10/13/04
Director of special education endorsement, 15.3(11), Filed **ARC 3733B** 10/13/04
School social worker statement of professional recognition, 15.3(15), Filed **ARC 3731B** 10/13/04
Renewal of licenses, 17.2, 17.4 to 17.7, 17.8(2), 17.9(2), 17.11(3) to 17.11(6), 17.11(7)"f," 17.11(8)"c" to "e," 17.12, Notice **ARC 3734B** 10/13/04

EDUCATION DEPARTMENT[281]
School bus driver's authorization, 43.1(4), 43.3, 43.6, 43.7, 43.10(4), 43.10(5)"b" and "e," 43.14 to 43.20, 43.22 to 43.24, 43.25(2), 43.25(8), 43.30 to 43.32, 43.34, 43.34(1), 43.34(8) to 43.34(10), 43.34(15), 43.34(16), 43.34(18), 43.34(19), 43.35, 43.35(5), 43.35(7), 43.36, 43.38(3), 43.39(4), 43.39(5), 43.43(2), 43.43(6)"b," Notice **ARC 3711B** 10/13/04

ELDER AFFAIRS DEPARTMENT[321]
Older Iowans legislature, rescind ch 20, Notice **ARC 3750B** 10/27/04

ENGINEERING AND LAND SURVEYING EXAMINING BOARD[193C]
Professional Licensing and Regulation Division[193]
COMMERCE DEPARTMENT[181]"umbrella"
Licensed professional engineers and building construction, 1.5, Filed **ARC 3727B** 10/13/04
Continuing education, 7.6, Filed **ARC 3728B** 10/13/04

ENVIRONMENTAL PROTECTION COMMISSION[567]
NATURAL RESOURCES DEPARTMENT[561]"umbrella"
Regulation of concentrated animal feeding operations (CAFOs) and confinement feeding operations; national pollutant discharge elimination system (NPDES) permitting, 60.2, 60.3(2)"c," 63.5, 64.3(1)"h"(2), 65.1, 65.2(2), 65.3(1), 65.4 to 65.6, 65.7(1)"a," 65.22, Notice **ARC 3736B** 10/13/04
Animal feeding operations—construction permits, master matrix, location of groundwater tables, 65.1, 65.7(1)"b," 65.7(5), 65.9(1)"p," 65.10(3)"b"(3), 65.15(7)"c," Notice **ARC 3735B** 10/13/04

HUMAN SERVICES DEPARTMENT[441]
Appeals and hearings for subjects of child or dependent adult abuse reports, 7.1, ch 175 div II title, 175.31(2), 175.40(3)"a" and "b," 175.42(3)"a," 175.42(3)"b"(4) and (5), Filed **ARC 3724B** 10/13/04
Family investment and food assistance programs, 9.10(20), 40.27(5)"i," 41.25(8), 41.26(1)"d," 41.27(9)"d," 65.30(6), Filed **ARC 3721B** 10/13/04
Health insurance data match program, 9.12(2)"b"(9), 76.13, Filed **ARC 3715B** 10/13/04
Food assistance—electronic application form, 65.2(1), 65.2(1)"a" and "d," Notice **ARC 3760B** 10/27/04
Medicaid coverage for employed persons with disabilities, 75.1(39)"b"(4), Filed Emergency After Notice **ARC 3714B** 10/13/04

HUMAN SERVICES DEPARTMENT[441] (Cont'd)

Annual update of statewide average costs of nursing facility, ICF/MR, and mental health institute care, 75.23(3), 75.24(3)"b," 75.24(3)"b"(1) to (5), Filed **ARC 3759B** 10/27/04

Medicaid reimbursement methodology, 79.1(1)"c," 79.1(2), 79.1(5)"r"(1), 79.1(5)"y"(2), (5) and (8), 79.1(16)"a" and "i," 79.1(16)"v"(2), 79.14(1), 79.14(1)"e," Filed **ARC 3716B** 10/13/04

Medicaid reimbursement for nursing facility services, 79.1(2), 81.6(16)"a," 81.6(16)"c"(3), Filed **ARC 3717B** 10/13/04

HCBS ill and handicapped waiver, 83.2(1)"b," 83.2(2)"b," Notice **ARC 3723B**, also Filed Emergency **ARC 3722B** 10/13/04

Suspension or reinstatement of support obligation—department assistance, 99.62(2), 99.83(6)"b," 99.101, 99.102, 99.103(1), 99.103(3), 99.104(2), 99.104(3)"b" and "c," 99.105(1), 99.105(2), 99.106, 99.107, 99.107(2), 99.107(4), 99.108(1), 99.108(2), 99.109, Notice **ARC 3328B** Terminated **ARC 3761B** 10/27/04

Continuation of rate limits for purchase of social service contracts and rehabilitative treatment and supportive service contracts, 150.3(5)"p"(2), 150.3(5)"p"(2)"3" and "4," 185.112(1)"k," Filed **ARC 3718B** 10/13/04

State payment program for services to adults with mental illness, mental retardation, and developmental disabilities, 153.52(1), 153.53(2), 153.57(3)"b," Filed **ARC 3719B** 10/13/04

Subsidized adoptions, 201.3(2), 201.6(1)"a"(4) and (7), Filed **ARC 3720B** 10/13/04

INSURANCE DIVISION[191]

COMMERCE DEPARTMENT[181]"umbrella"

Confidentiality of investigations files; cease and desist orders, 1.3(10)"d" to "j," 1.3(11)"f," 3.32, 15.2, 15.14, Notice **ARC 3752B** 10/27/04

Medicare supplement insurance minimum standards, 37.3, 37.4, 37.5(4) to 37.5(6), 37.6(1)"e"(5), 37.6(1)"f," 37.6(2)"f," 37.7(1)"e"(6), 37.7(1)"f," 37.7(1)"g"(3)"2," 37.7(2), 37.7(2)"c," 37.7(3)"f," "g" and "i," 37.7(3)"i"(2) and (3), 37.7(3)"k," 37.7(4), 37.7(5), 37.8(2), 37.8(3), 37.8(5) to 37.8(7), 37.9(9)"c," 37.9(13)"b," 37.9(14)"b," 37.10(3), 37.12(1)"a"(2), 37.13(2) to 37.13(6), 37.15(1)"f"(1), 37.15(3), 37.15(4), 37.15(4)"c" and "d," 37.15(5), 37.16(1), 37.16(1)"a"(4) to (6), 37.16(1)"b," 37.16(5), 37.16(6), 37.19, 37.24(1), 37.24(2)"c"(3), 37.24(2)"g," 37.24(3)"a," "e" and "f," 37.24(5), ch 37 appendices A and C, Notice **ARC 3753B** 10/27/04

IOWA FINANCE AUTHORITY[265]

ECONOMIC DEVELOPMENT, IOWA DEPARTMENT OF[261]"umbrella"

Multifamily loans, ch 3 div I title, 3.1, 3.3 to 3.11, 3.20, 3.21, 3.23, 3.24, 3.24(1), 3.24(3)"d," ch 3 div III, 3.31 to 3.37, Filed **ARC 3757B** 10/27/04

State housing trust fund, 19.1, Filed **ARC 3758B** 10/27/04

NURSING BOARD[655]

PUBLIC HEALTH DEPARTMENT[641]"umbrella"

Reactivation process, 3.1, 3.7(4) to 3.7(8), 3.8, 4.7"4," 5.2(2), 5.2(2)"a"(4), 5.2(2)"c," 5.2(4), 5.2(5)"b" to "h," Filed **ARC 3747B** 10/27/04

PETROLEUM UST FUND BOARD, IOWA COMPREHENSIVE[591]

Aboveground petroleum storage tank fund, adopt ch 14, Filed **ARC 3748B** 10/27/04

PROFESSIONAL LICENSURE DIVISION[645]

PUBLIC HEALTH DEPARTMENT[641]"umbrella"

Respiratory care practitioners, 261.8(4)"b," 261.9(4), 261.9(6), 261.10(6), 262.2(1), 262.2(2), 262.6"6," 262.10(2)"b," Filed **ARC 3756B** 10/27/04

PUBLIC SAFETY DEPARTMENT[661]

Peace officers' retirement, accident, and disability system, rescind 581—ch 24; adopt 661—chs 400 to 404, Filed **ARC 3749B** 10/27/04

REGENTS BOARD[681]

Application fees, 1.1, 1.2, 1.7, 2.27(1), 2.27(6), Filed Emergency **ARC 3743B** 10/13/04

Personnel administration, 3.2, 3.37, 3.104(4)"c," 3.115, Filed **ARC 3744B** 10/13/04

Notification of increase in tuition, fees or charges, 9.6, Notice **ARC 3745B** 10/13/04

Organization, 11.1, Filed **ARC 3746B** 10/13/04

REVENUE DEPARTMENT[701]

Additional first-year depreciation allowance, Section 179 expensing, 40.60, 40.65, 53.22, 53.23, 59.23, 59.24, Filed Emergency **ARC 3742B** 10/13/04

Property rehabilitation tax credit; university-based research utilization program tax credit, 42.15(2), 42.21, 52.18(2), 52.24, Notice **ARC 3754B** 10/27/04

Tax credit for an equity investment in a qualifying business, 42.18(1), 52.21(1), 58.11(1), Filed **ARC 3741B** 10/13/04

TELECOMMUNICATIONS AND TECHNOLOGY COMMISSION, IOWA[751]
Organization; contracts for professional services; purchasing, 1.4 to 1.7, 2.3(7)"b"(1) and (5), 2.3(7)"d," 5.1(2)"f," 5.7(1)"g," 5.15, 5.20; rescind ch 6; 7.1, 7.2, 8.3, 13.1(2), 14.4, 18.5(3)"a," 18.5(5), 18.6(4) to 18.6(11), 18.12(1)"b" and "f," Notice **ARC 3713B** 10/13/04

TRANSPORTATION DEPARTMENT[761]
Fleet deletions; destruction of motor vehicle credentials, 500.1, 500.4(2)"a" and "b," 500.10 to 500.25, Notice **ARC 3712B** 10/13/04

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Pipelines and electric lines, 10.1(4), 10.2(1)"f," 10.12(1), 10.14(2), 10.16, 10.17, 11.1(8), 11.2(1)"d"(2), 11.3(1), 13.1(4), 13.2(1)"f," 13.14(2), 15.10(1)"h," 19.2(5)"g," 19.5(2), 19.6(3), 19.8(3), 19.8(6), 20.1(3), 20.5(2)"j," 25.2(2)"g," 25.2(5)"b," 25.3(5), Filed **ARC 3729B** 10/13/04
Level payment plans, 19.4(11)"e," 20.4(12)"e," Filed **ARC 3755B** 10/27/04

ADMINISTRATIVE RULES REVIEW COMMITTEE MEMBERS

Regular statutory meetings are held the second Tuesday of each month at the seat of government as provided in Iowa Code section 17A.8. A special meeting may be called by the Chair at any place in the state and at any time.
EDITOR'S NOTE: Terms ending April 30, 2007.

Senator Michael Connolly
3458 Daniels Street
Dubuque, Iowa 52002

Senator John P. Kibbie
P.O. Box 190
Emmetsburg, Iowa 50536

Senator Mary Lundby
P.O. Box 648
Marion, Iowa 52302-0648

Senator Paul McKinley
21884 483rd Lane
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Emmetsburg, Iowa 50536

Representative David Heaton
510 East Washington
Mt. Pleasant, Iowa 52641

Representative Geri Huser
213 Seventh Street NW
Altoona, Iowa 50009

Gary Dickey Jr.
Administrative Rules Coordinator
Governor's Ex Officio Representative
Capitol, Room 11
Des Moines, Iowa 50319

To All Agencies:
The Administrative Rules Review Committee voted to request that Agencies comply with Iowa Code section 17A.4(1)"b" by allowing the opportunity for oral presentation (hearing) to be held at least **twenty** days after publication of Notice in the Iowa Administrative Bulletin.

AGENCY	HEARING LOCATION	DATE AND TIME OF HEARING
ATTORNEY GENERAL[61]		
Victim services grant program, 9.50 to 9.65 IAB 10/13/04 **ARC 3725B**	Division Conference Room Ground Floor Lucas State Office Bldg. Des Moines, Iowa	November 2, 2004 10 a.m.
CORRECTIONS DEPARTMENT[201]		
Community-based corrections administration, 40.1, 40.4, 40.5 IAB 10/13/04 **ARC 3726B**	Second Floor Conference Room 420 Watson Powell Jr. Way Des Moines, Iowa	November 2, 2004 11 a.m. to 1 p.m.
ECONOMIC DEVELOPMENT, IOWA DEPARTMENT OF[261]		
Special provisions for the American Dream Downpayment Initiative, 25.4(4) IAB 10/13/04 **ARC 3730B**	First Floor Northwest Conference Rm. 200 E. Grand Ave. Des Moines, Iowa	November 2, 2004 1:30 p.m.
EDUCATIONAL EXAMINERS BOARD[282]		
Renewal of licenses, 17.2, 17.4 to 17.9, 17.11, 17.12 IAB 10/13/04 **ARC 3734B**	Room 2 Southwest, Second Floor Grimes State Office Bldg. Des Moines, Iowa	November 2, 2004 1 p.m.
EDUCATION DEPARTMENT[281]		
School transportation, amendments to ch 43 IAB 10/13/04 **ARC 3711B**	State Board Room, Second Floor Grimes State Office Bldg. Des Moines, Iowa	November 2, 2004 1 p.m.
ELDER AFFAIRS DEPARTMENT[321]		
Older Iowans legislature, rescind ch 20 IAB 10/27/04 **ARC 3750B** **(ICN Network)**	Public Library 415 Commercial St. Waterloo, Iowa	November 16, 2004 1:30 p.m.
	Indian Hills Community College − 8 Bldg. 14, 651 Indian Hills Dr. Ottumwa, Iowa	November 16, 2004 1:30 p.m.
	Third Floor Conference Room Wallace State Office Bldg. Des Moines, Iowa	November 16, 2004 1:30 p.m.

ELDER AFFAIRS DEPARTMENT[321] (Cont'd)
(ICN Network)

	Public Library 21 E. Third St. Spencer, Iowa (South entrance under canopy)	November 16, 2004 1:30 p.m.
	Public Library 400 Willow Ave. Council Bluffs, Iowa (South side main entrance)	November 16, 2004 1:30 p.m.

ENVIRONMENTAL PROTECTION COMMISSION[567]

Concentrated animal feeding operations (CAFOs); NPDES permitting, 60.2, 60.3(2), 63.5, 64.3(1), 65.1 to 65.7, 65.22 IAB 10/13/04 **ARC 3736B**	Cass County Community Center 805 W. Tenth St. Atlantic, Iowa	November 2, 2004 9 a.m.
	Plymouth County Extension 24 First St. NW Le Mars, Iowa	November 2, 2004 6:30 p.m.
	Marr Park 2943 Hwy 92 Ainsworth, Iowa	November 4, 2004 6:30 p.m.
	Parks and Recreation Offices 200 First St. NE Waverly, Iowa	November 5, 2004 8:30 a.m.
	Fifth Floor Conference Room Wallace State Office Bldg. Des Moines, Iowa	November 5, 2004 1:30 p.m.
Animal feeding operations—construction permits, use of master matrix, 65.1, 65.7, 65.9, 65.10, 65.15 IAB 10/13/04 **ARC 3735B**	Fifth Floor Conference Rooms Wallace State Office Bldg. Des Moines, Iowa	November 8, 2004 8:30 a.m.

INSURANCE DIVISION[191]

Confidential records; cease and desist orders, 1.3, 3.32, 15.2, 15.14 IAB 10/27/04 **ARC 3752B**	330 Maple St. Des Moines, Iowa	November 16, 2004 10:30 a.m.
Medicare supplement insurance minimum standards, amendments to ch 37 IAB 10/27/04 **ARC 3753B**	330 Maple St. Des Moines, Iowa	November 16, 2004 10 a.m.

TELECOMMUNICATIONS AND TECHNOLOGY COMMISSION, IOWA[751]

General, amendments to chs 1, 2, 5 to 8, 13, 14, 18 IAB 10/13/04 **ARC 3713B**	Thompson Conference Room Building W-4, Camp Dodge Johnston, Iowa	November 2, 2004 1 p.m.

TRANSPORTATION DEPARTMENT[761]

Interstate registration and operation of vehicles, 500.1, 500.4, 500.10 to 500.25 IAB 10/13/04 **ARC 3712B**	DOT Conference Room Park Fair Mall 100 Euclid Ave. Des Moines, Iowa	November 4, 2004 10 a.m. (If requested)

CITATION of Administrative Rules

The Iowa Administrative Code shall be cited as (agency identification number) IAC (chapter, rule, subrule, lettered paragraph, or numbered subparagraph).

441 IAC 79	(Chapter)
441 IAC 79.1(249A)	(Rule)
441 IAC 79.1(1)	(Subrule)
441 IAC 79.1(1)“a”	(Paragraph)
441 IAC 79.1(1)“a”(1)	(Subparagraph)

The Iowa Administrative Bulletin shall be cited as IAB (volume), (number), (publication date), (page number), (ARC number).

IAB Vol. XII, No. 23 (5/16/90) p. 2050, ARC 872A

Due to reorganization of state government by 1986 Iowa Acts, chapter 1245, it was necessary to revise the agency identification numbering system, i.e., the bracketed number following the agency name.

"Umbrella" agencies and elected officials are set out below at the left-hand margin in CAPITAL letters.

Divisions (boards, commissions, etc.) are indented and set out in lowercase type under their statutory "umbrellas."

Other autonomous agencies which were not included in the original reorganization legislation as "umbrella" agencies are included alphabetically in small capitals at the left-hand margin, e.g., BEEF INDUSTRY COUNCIL, IOWA[101].

The following list will be updated as changes occur:

ADMINISTRATIVE SERVICES DEPARTMENT[11]
AGRICULTURE AND LAND STEWARDSHIP DEPARTMENT[21]
- Agricultural Development Authority[25]
- Soil Conservation Division[27]

ATTORNEY GENERAL[61]
AUDITOR OF STATE[81]
BEEF INDUSTRY COUNCIL, IOWA[101]
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ARC 3750B

ELDER AFFAIRS DEPARTMENT[321]

Notice of Intended Action

Twenty-five interested persons, a governmental subdivision, an agency or association of 25 or more persons may demand an oral presentation hereon as provided in Iowa Code section 17A.4(1)"*b*."

Notice is also given to the public that the Administrative Rules Review Committee may, on its own motion or on written request by any individual or group, review this proposed action under section 17A.8(6) at a regular or special meeting where the public or interested persons may be heard.

Pursuant to the authority of Iowa Code section 231.14, the Elder Affairs Department hereby gives Notice of Intended Action to rescind Chapter 20, "Older Iowans Legislature," Iowa Administrative Code.

The reasons for this action are:

1. The Department supports empowerment of seniors advocating on behalf of seniors. Therefore, the Department promotes transitioning the Older Iowans Legislature project to an independent and autonomous organization.
2. In its desire to expand its advocacy efforts, the Department continues to explore both outreach and educational opportunities related to aging that meet the needs of all Iowans and comply with both the federal Older Americans Act and the Elder Act.
3. Currently there is no statutory authority for the Department to convene the Older Iowans Legislature, and there are no general fund moneys appropriated for this event.
4. The Department has worked in a collaborative manner with the Iowa Association of Area Agencies on Aging and Older Iowans Legislature leadership in exploring alternate advocacy initiatives related to the public policy efforts.

Any interested person may make written suggestions or comments on this proposed amendment on or before November 16, 2004. Such written comments should be directed to the Department of Elder Affairs, 200 10th Street, Des Moines, Iowa 50309; or E-mailed to sherry.james@iowa.gov; or faxed to (515)242-3300.

There will be a public hearing November 16, 2004, at 1:30 p.m. over the Iowa Communications Network (ICN), at which time persons may present their views either orally or in writing. Access to the public hearing will be available through the following locations:

Public Library
415 Commercial Street
Waterloo

Indian Hills Community College - 8
651 Indian Hills Drive, Bldg. 14
Ottumwa

Department of Public Safety
Wallace State Office Building
502 East Ninth Street
Third Floor Conference Room
Des Moines

Spencer Public Library
21 East Third Street
(Use south entrance under canopy.)
Spencer

Public Library
400 Willow Avenue
(Use south side main entrance; check sign for room location.)
Council Bluffs

At the public hearing, persons will be asked to give their names and addresses for the record and to confine their remarks to the subject of the amendment.

Any persons who intend to attend the public hearing and have special requirements, such as those relating to hearing or mobility impairments, should contact the Elder Affairs Department and advise of specific needs.

A fiscal impact summary prepared by the Legislative Services Agency pursuant to Iowa Code Supplement § 17A.4(3) will be available at http://www.legis.state.ia.us/IAC.html or at (515)281-5279 prior to the Administrative Rules Review Committee's review of this rule making.

The following amendment is proposed.

Rescind and reserve **321—Chapter 20**.

ARC 3760B

HUMAN SERVICES DEPARTMENT[441]

Notice of Intended Action

Twenty-five interested persons, a governmental subdivision, an agency or association of 25 or more persons may demand an oral presentation hereon as provided in Iowa Code section 17A.4(1)"*b*."

Notice is also given to the public that the Administrative Rules Review Committee may, on its own motion or on written request by any individual or group, review this proposed action under section 17A.8(6) at a regular or special meeting where the public or interested persons may be heard.

Pursuant to the authority of Iowa Code section 234.6(4), the Department of Human Services proposes to amend Chapter 65, "Food Assistance Program Administration," Iowa Administrative Code.

These amendments will allow people seeking Food Assistance to apply over the Internet using an electronic application form. This method of applying will be faster and more convenient than obtaining and completing a paper application form and bringing or mailing it to the local office. A summary of the data collected through the electronic application will be made available to the Department local office for application processing. Applicants may also print the summary if they choose to do so.

These amendments do not provide for waivers in specified situations because they provide a benefit to prospective applicants by giving them more ways to apply for Food Assistance.

Any interested person may make written comments on the proposed amendments on or before November 17, 2004. Comments should be directed to the Office of Policy Analysis, Department of Human Services, Hoover State Office Building, 1305 East Walnut Street, Des Moines, Iowa 50319-0114. Comments may be sent by fax to (515)281-4980 or by E-mail to policyanalysis@dhs.state.ia.us.

These amendments are intended to implement Iowa Code section 234.12 and 7 Code of Federal Regulations 273.2(b)(5) and 273.2(c)(1).

A fiscal impact summary prepared by the Legislative Services Agency pursuant to Iowa Code Supplement § 17A.4(3) will be available at http://www.legis.state.ia.us/IAC.html or

at (515)281-5279 prior to the Administrative Rules Review Committee's review of this rule making.

The following amendments are proposed.

Amend subrule 65.2(1) as follows:

Amend the introductory paragraph as follows:

65.2(1) Application filing. Persons in need of food assistance benefits may file an application at any local department office in Iowa *or over the Internet*.

Amend paragraphs **"a"** and **"d"** as follows:

a. An application is filed the day a local department office receives an application for food assistance benefits ~~on Form 470-0306 or 470-0307 (Spanish), Application for Food Assistance, or Form 470-0462 or Form 470-0466 (Spanish), Public Assistance Application, containing~~ *that contains* the applicant's name and address~~, which~~ *and that* is signed by either a responsible member of the household or the household's authorized representative. *The application may be filed on:*

(1) Form 470-0306 or 470-0307 (Spanish), Application for Food Assistance;

(2) Form 470-0462 or Form 470-0466 (Spanish), Public Assistance Application; or

(3) Form 470-4080 or 470-4080(S) (Spanish), Electronic Food Assistance Application.

d. The application is complete when a completed ~~Form 470-0306, 470-0307, 470-0462, or 470-0466,~~ *form as specified in paragraph 65.2(1)"a"* is submitted.

ARC 3761B

HUMAN SERVICES DEPARTMENT[441]

Notice of Termination

Pursuant to the authority of Iowa Code sections 217.6, 252B.20(1)"e," and 252H.4(4), the Department of Human Services terminates the rule making initiated by its Notice of Intended Action published in the Iowa Administrative Bulletin on April 28, 2004, as **ARC 3328B**, to amend Chapter 99, "Support Establishment and Adjustment Services," Iowa Administrative Code.

The Notice of Intended Action proposed amendments to allow the Child Support Recovery Unit to assist parents, under certain conditions, in suspending or reinstating a support obligation for individual children affected by a support order, rather than the current practice of offering assistance only when the changes affect all of the children under the order.

Although the Department received no comments on the Notice of Intended Action, ensuing discussions have shown that the issue of parents changing physical custody and the impact on the child support order is much broader than can be addressed in these rules. Therefore, the Department is terminating rule making for **ARC 3328B**.

ARC 3752B

INSURANCE DIVISION[191]

Notice of Intended Action

Twenty-five interested persons, a governmental subdivision, an agency or association of 25 or more persons may demand an oral presentation hereon as provided in Iowa Code section 17A.4(1)"*b*."

Notice is also given to the public that the Administrative Rules Review Committee may, on its own motion or on written request by any individual or group, review this proposed action under section 17A.8(6) at a regular or special meeting where the public or interested persons may be heard.

Pursuant to the authority of Iowa Code chapters 17A and 502 and sections 505.8(2) and 507B.12 and 2004 Iowa Acts, House File 2489, the Insurance Division hereby gives Notice of Intended Action to amend Chapter 1, "Organization of Division," Chapter 3, "Contested Cases," and Chapter 15, "Unfair Trade Practices," Iowa Administrative Code.

The proposed amendments are intended to implement the provisions of 2004 Iowa Acts, House File 2489, which became effective July 1, 2004. The legislation makes investigation files of the Division confidential, but does permit the Division to share information between a consumer who files a complaint and the subject of the complaint. The legislation also clarifies the authority of the Commissioner of Insurance to issue orders to require that persons cease and desist from actions violating insurance law. The amendments are intended to bring existing rules into compliance with the new legislation.

These rules do not provide for waivers. A person seeking a waiver must petition the Division for a waiver in the manner set forth in 191—Chapter 4.

A public hearing will be held at the offices of the Insurance Division at 10:30 a.m. on November 16, 2004. The Division is located at 330 Maple, Des Moines, Iowa 50319. At the hearing, persons will be asked to give their names and addresses for the record and to confine their remarks to the subject of the proposed amendments.

Any person who intends to attend the public hearing and requires special accommodations should contact the Division at (515)281-5705.

Any interested person may make written comments on the proposed amendments on or before November 16, 2004. Written comments may be sent to Rosanne Mead, Assistant Commissioner, Insurance Division, 330 Maple, Des Moines, Iowa 50319. Comments may also be submitted electronically to: rosanne.mead@iid.state.ia.us.

These amendments are intended to implement 2004 Iowa Acts, House File 2489.

A fiscal impact summary prepared by the Legislative Services Agency pursuant to Iowa Code Supplement § 17A.4(3) will be available at http://www.legis.state.ia.us/IAC.html or at (515)281-5279 prior to the Administrative Rules Review Committee's review of this rule making.

The following amendments are proposed.

ITEM 1. Amend subrule **1.3(10)** by rescinding paragraph **"d"** and relettering paragraphs **"e"** to **"j"** as **"d"** to **"i."**

ITEM 2. Amend paragraph **1.3(11)"f"** as follows:

f. Complaint files, investigation files, other investigative reports and other investigative information of the agency relating to discipline of licensed insurance agents~~. Iowa Code section 272C.6(4).~~ *, except as allowed under Iowa Code section 505.8(6), 505.17, 507A.10 as amended by 2004 Iowa Acts, House File 2489, section 19, or 507B.3 as amended by 2004 Iowa Acts, House File 2489, section 21*.

INSURANCE DIVISION[191](cont'd)

ITEM 3. Amend rule 191—3.32(502,505) as follows:

191—3.32(502,505,*507B*) Summary cease and desist orders. When a statute authorizes action to be taken without a prior hearing, the ~~insurance division's~~ *commissioner's* order shall be sent to the last-known address of the party by certified mail, return receipt requested, unless the party is a licensee, in which case the order shall be sent by restricted certified mail. The order shall ~~state the reasons for the division's action, cite the law or rule involved,~~ *include a brief statement of findings of fact, conclusions of law and policy reasons for the decision; direct the person or insurer to cease and desist from engaging in the act or practice or to take other affirmative action as is necessary, in the judgment of the commissioner, to comply with the statute;* and state that the party will be afforded a *contested case proceeding and a* hearing~~,~~ if a ~~hearing is requested within~~ *request is filed with the commissioner at least* 30 days ~~of~~ *from* the date ~~of the signing of~~ *that* the order *is issued*, unless a different time is specified by statute. The ~~insurance division~~ *commissioner* shall issue a notice of hearing no later than 30 days from the date of receipt of a timely request for *a contested case proceeding and* hearing. If a statute requires a hearing to be held following issuance of a summary order, the date and time of that hearing shall be set forth in the order. Summary orders shall remain effective during the pendency of proceedings.

ITEM 4. Amend rule **191—15.2(507B)** by rescinding the definition of "person" and adopting the following **new** definition in lieu thereof:

"Person" shall mean any individual, corporation, association, partnership, reciprocal exchange, interinsurer, fraternal beneficiary association, and any other legal entity engaged in the business of insurance, including agents, brokers and adjusters. "Person" shall also mean any corporation operating under the provisions of Iowa Code chapter 514 and any benevolent association as defined and operated under Iowa Code chapter 512A. For purposes of this chapter, corporations operating under the provisions of Iowa Code chapter 514 and Iowa Code chapter 512A shall be deemed to be engaged in the business of insurance.

ITEM 5. Amend rule 191—15.14(507B) as follows:

191—15.14(*505*,507B) Enforcement section—cease and desist and penalty orders.

15.14(1) If, after hearing, the commissioner ~~finds~~ *determines* that ~~an insurer or producer~~ *a person* has engaged in an unfair trade practice in violation of these rules ~~or~~ *, an* unfair *method of* competition, or *an* unfair ~~and~~ *or* deceptive ~~acts or practices~~ *act or practice* in violation of Iowa Code chapter 507B, the commissioner shall reduce the findings to writing and shall issue and cause to be served upon the ~~insurer or producer~~ *person* charged with the violation a copy of ~~the~~ *such* findings ~~in~~ *and* an order requiring ~~the insurer or producer~~ *the person* to cease and desist from engaging in ~~the~~ *such method of competition*, act or practice. The commissioner also may order one or more of the following:

~~1~~ *a.* Payment of a ~~monetary~~ *civil* penalty of not more than $1,000 for each *act or* violation, but not to exceed an aggregate penalty of $10,000~~. If the insurer or producer~~, *unless the person* knew or reasonably should have known that ~~its~~ *the* actions were in violation of these rules *or of Iowa Code chapter 507B, in which case* the penalty shall be not more than $5,000 for each *act or* violation, but not to exceed an aggregate penalty of $50,000 *in any one six-month period. If the commissioner finds that a violation of these rules or of Iowa Code chapter 507B was directed, encouraged, condoned, ignored, or ratified by the employer of the person or by an insurer, the commissioner shall also assess a fine to the employer or insurer*;

~~2~~ *b.* Suspension or revocation of ~~the~~ *an* insurer's certificate of authority or the producer's license if the insurer or producer knew or reasonably should have known that it was in violation of ~~this rule~~ *these rules or of Iowa Code chapter 507B*;

c. Payment of interest at the rate of 10 percent per annum if the commissioner finds that the insurer failed to pay interest as required under Iowa Code section 507B.4, subsection 12;

~~3~~ *d.* Full disclosure by the insurer of all terms and conditions of the policy to the policyowner;

~~4~~ *e.* Payment of the costs of the investigation and administrative expenses related to any *act or* violation. *The commissioner may retain funds collected pursuant to any settlement, enforcement action, or other legal action authorized under federal or state law for the purpose of reimbursing costs and expenses of the division.*

15.14(2) *Any person who violates a cease and desist order of the commissioner while such order is in effect may, after notice and hearing and upon order of the commissioner, be subject at the discretion of the commissioner to one or both of the following:*

a. A civil penalty of not more than $10,000 for each and every act or violation.

b. Suspension or revocation of such person's license.

ARC 3753B

INSURANCE DIVISION[191]

Notice of Intended Action

Twenty-five interested persons, a governmental subdivision, an agency or association of 25 or more persons may demand an oral presentation hereon as provided in Iowa Code section 17A.4(1)*"b."*

Notice is also given to the public that the Administrative Rules Review Committee may, on its own motion or on written request by any individual or group, review this proposed action under section 17A.8(6) at a regular or special meeting where the public or interested persons may be heard.

Pursuant to the authority of Iowa Code section 505.8 and chapter 514D, the Insurance Division hereby gives Notice of Intended Action to amend Chapter 37, "Medicare Supplement Insurance Minimum Standards," Iowa Administrative Code.

These amendments update Chapter 37 to conform to the recently adopted amendments to the National Association of Insurance Commissioners (NAIC) Model Regulation to Implement the Medicare Supplement Insurance Minimum Standards Model Act. These amendments are required to bring Iowa regulations into compliance with the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

The main focus of these amendments is to implement the provisions to Medicare supplement plans that offer an outpatient prescription drug benefit. These amendments also prescribe the manner in which insurers are to amend current policies and establish guidelines for sales on or after January 1, 2006. Two new Medicare supplement plans are created, plans "K" and "L." The amendments strike and replace all existing outlines of coverage and disclosure documents.

These amendments do not contain a waiver provision. The Division has previously adopted a general waiver provision in 191—Chapter 4.

INSURANCE DIVISION[191](cont'd)

A public hearing will be held at the offices of the Insurance Division at 10 a.m. on November 16, 2004. The Division is located at 330 Maple Street, Des Moines, Iowa 50319. At the hearing, persons will be asked to give their names and addresses for the record and to confine their remarks to the subject of the proposed amendments.

Any person who intends to attend the public hearing and requires special accommodations should contact the Division at (515)281-5705.

Any interested person may make written comments on the proposed amendments on or before November 16, 2004. Written comments should be sent to Rosanne Mead, Assistant Insurance Commissioner, at the address listed above. Comments may be submitted electronically to rosanne.mead@iid.state.ia.us.

These amendments are intended to implement Iowa Code chapter 514D.

A fiscal impact summary prepared by the Legislative Services Agency pursuant to Iowa Code Supplement § 17A.4(3) will be available at http://www.legis.state.ia.us/IAC.html or at (515)281-5279 prior to the Administrative Rules Review Committee's review of this rule making.

The following amendments are proposed.

ITEM 1. Amend **191—Chapter 37** by striking all references to "Medicare+Choice" and "Medicare+Choice plan" and replacing them with "Medicare Advantage."

ITEM 2. Amend rule **191—37.3(514D)**, definitions of "Medicare Advantage" and "Medicare supplement policy," as follows:

"Medicare Advantage" means a plan of coverage for health benefits under Medicare Part C (as defined in ~~Section 1859 found in Title IV, Subtitle A, Chapter 1 of P.L. 105-33~~ *42 U.S.C. 1395w-28(b)(1)*), and includes:

1. to 3. No change.

"Medicare supplement policy" means a group or individual policy of accident and sickness insurance or a subscriber contract of hospital and medical service associations or health maintenance organizations, other than a policy issued pursuant to a contract under Section 1876 of the federal Social Security Act (42 U.S.C. Section 1395 et seq.) or an issued policy under a demonstration project specified in 42 U.S.C. Section 1395ss(g)(1), which is advertised, marketed or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical or surgical expenses of persons eligible for Medicare. *"Medicare supplement policy" does not include Medicare Advantage plans established under Medicare Part C, Outpatient Prescription Drug plans established under Medicare Part D, or any Health Care Prepayment Plan (HCPP) that provides benefits pursuant to an agreement under §1833(a)(1)(A) of the Social Security Act.*

ITEM 3. Amend rule **191—37.4(514D)**, definitions of "health care expenses" and "Medicare eligible expenses," as follows:

"Health care expenses" means, *for purposes of rule 37.12(514D)*, expenses of health maintenance organizations associated with the delivery of health care services, which expenses are analogous to incurred losses of insurers.

~~Such expenses shall not include:~~

~~1. Home office and overhead costs;~~

~~2. Advertising costs;~~

~~3. Commissions and other acquisition costs;~~

~~4. Taxes;~~

~~5. Capital costs;~~

~~6. Administrative costs; and~~

~~7. Claims processing costs.~~

"Medicare eligible expenses" shall mean expenses of the kinds covered by Medicare *Parts A and B*, to the extent recognized as reasonable and medically necessary by Medicare.

ITEM 4. Adopt **new** subrules 37.5(4) to 37.5(6) as follows:

37.5(4) Subject to paragraphs 37.6(1)"d," "e," and "g" and 37.7(1)"d" and "e," a Medicare supplement policy with benefits for outpatient prescription drugs in existence prior to January 1, 2006, shall be renewed for current policyholders who do not enroll in Medicare Part D at the option of the policyholder.

37.5(5) A Medicare supplement policy with benefits for outpatient prescription drugs shall not be issued after December 31, 2005.

37.5(6) After December 31, 2005, a Medicare supplement policy with benefits for outpatient prescription drugs may not be renewed after the policyholder enrolls in Medicare Part D unless:

a. The policy is modified to eliminate outpatient prescription coverage for expenses of outpatient prescription drugs incurred after the effective date of the individual's coverage under a Medicare Part D plan; and

b. Premiums are adjusted to reflect the elimination of outpatient prescription drug coverage at the time of Medicare Part D enrollment, accounting for any claims paid, if applicable.

ITEM 5. Amend rule 191—37.6(514D) as follows:

Adopt **new** subparagraph **37.6(1)"e"(5)** as follows:

(5) If a Medicare supplement policy eliminates an outpatient prescription drug benefit as a result of requirements imposed by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, the modified policy shall be deemed to satisfy the guaranteed renewal requirements of this subrule.

Amend paragraph **37.6(1)"f"** as follows:

f. Termination of a Medicare supplement policy or certificate shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be predicated upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or to payment of the maximum benefits. *Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.*

Rescind paragraph **37.6(2)"f"** and adopt the following **new** paragraph in lieu thereof:

f. Coverage for the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the copayment amount, of Medicare eligible expenses under Part B regardless of hospital confinement, subject to a maximum calendar year out-of-pocket amount equal to the Medicare Part B deductible ($100);

ITEM 6. Amend subrule 37.7(1) as follows:

Adopt **new** subparagraph **37.7(1)"e"(6)** as follows:

(6) If a Medicare supplement policy eliminates an outpatient prescription drug benefit as a result of requirements imposed by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, the modified policy shall be deemed to satisfy the guaranteed renewal requirements of this subrule.

Amend paragraph **37.7(1)"f"** as follows:

f. Termination of a Medicare supplement policy or certificate shall be without prejudice to any continuous loss which commenced while the policy was in force, but the ex-

tension of benefits beyond the period during which the policy was in force may be conditioned upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits. *Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.*

Rescind paragraph **37.7(1)"g"(3)"2"** and adopt the following **new** paragraph in lieu thereof:

2. Shall provide for resumption of coverage that is substantially equivalent to coverage in effect before the date of suspension. If the suspended Medicare supplement policy provided coverage for outpatient prescription drugs, reinstitution of the policy for Medicare Part D enrollees shall be without coverage for outpatient prescription drugs and shall otherwise provide substantially equivalent coverage to the coverage in effect before the date of suspension; and

ITEM 7. Amend subrule 37.7(2), catchwords and paragraph **"c,"** as follows:

37.7(2) Standards for Basic ("Core") Benefits Common to ~~All~~ *A − J* Benefit Plans.

c. Upon exhaustion of the Medicare hospital inpatient coverage including the lifetime reserve days, coverage of *100 percent of* the Medicare Part A Eligible Expenses for hospitalization paid at the ~~Diagnostic Related Group (DRG) day outlier per diem~~ *applicable prospective payment system (PPS) rate* or other appropriate *Medicare* standard of payment, subject to a lifetime maximum benefit of an additional 365 days. *The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance.*

ITEM 8. Amend subrule **37.7(3)** as follows:

Amend paragraphs **"f"** and **"g"** as follows:

f. Basic Outpatient Prescription Drug Benefit: Coverage for 50 percent of outpatient prescription drug charges, after a $250 calendar year deductible, to a maximum of $1,250 in benefits received by the insured per calendar year to the extent not covered by Medicare. *The outpatient prescription drug benefit may be included for sale or issuance in a Medicare supplement policy until January 1, 2006.*

g. Extended Outpatient Prescription Drug Benefit: Coverage for 50 percent of outpatient prescription drug charges, after a $250 calendar year deductible to a maximum of $3,000 in benefits received by the insured per calendar year, to the extent not covered by Medicare. *The outpatient prescription drug benefit may be included for sale or issuance in a Medicare supplement policy until January 1, 2006.*

Amend paragraph **"i"** as follows:

Amend the introductory paragraph as follows:

i. Preventive Medical Care Benefit: Coverage for the following preventive health services *not covered by Medicare*:

Rescind subparagraphs **(2)** and **(3)** and adopt the following **new** subparagraph **(2)**:

(2) Preventive screening tests or preventive services, the selection and frequency of which is determined to be medically appropriate by the attending physician.

Rescind paragraph **"k."**

ITEM 9. Adopt **new** subrules 37.7(4) and 37.7(5) as follows:

37.7(4) Standards for Plan "K." Standardized Medicare supplement benefit plan "K" shall consist of the following:

a. Coverage of 100 percent of the Part A hospital coinsurance amount for each day used from the sixty-first through the ninetieth day in any Medicare benefit period;

b. Coverage of 100 percent of the Part A hospital coinsurance amount for each Medicare lifetime inpatient reserve day used from the ninety-first through the one hundred fiftieth day in any Medicare benefit period;

c. Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 100 percent of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment in full and may not bill the insured for any balances;

d. Medicare Part A Deductible: Coverage for 50 percent of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in paragraph "j";

e. Skilled Nursing Facility Care: Coverage for 50 percent of the coinsurance amount for each day used from the twenty-first day through the one hundredth day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A until the out-of-pocket limitation is met as described in paragraph "j";

f. Hospice Care: Coverage for 50 percent of cost sharing for all Part A Medicare eligible expenses and respite care until the out-of-pocket limitation is met as described in paragraph "j";

g. Coverage for 50 percent, under Medicare Part A or B, of the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations until the out-of-pocket limitation is met as described in paragraph "j";

h. Except for coverage provided in paragraph "i," coverage for 50 percent of the cost sharing otherwise applicable under Medicare Part B after the policyholder pays the Part B deductible until the out-of-pocket limitation is met as described in paragraph "j";

i. Coverage of 100 percent of the cost sharing for Medicare Part B preventive services after the policyholder pays the Part B deductible; and

j. Coverage of 100 percent of all cost sharing under Medicare Parts A and B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under Medicare Parts A and B of $4,000 in 2006, indexed each year by the appropriate inflation adjustment specified by the Secretary of the U.S. Department of Health and Human Services.

37.7(5) Standards for Plan "L." Standardized Medicare supplement benefit plan "L" shall consist of the following:

a. The benefits described in paragraphs 37.7(4)"a," "b," "c," and "i";

b. The benefits described in paragraphs 37.7(4)"d," "e," "f," "g," and "h" but substituting 75 percent for 50 percent; and

c. The benefits described in paragraph 37.7(4)"j" but substituting $2,000 for $4,000.

ITEM 10. Amend rule 191—37.8(514D) as follows:

Amend subrules 37.8(2), 37.8(3) and 37.8(5) as follows:

37.8(2) No groups, packages or combinations of Medicare supplement benefits other than those listed in this ~~section~~ *rule* shall be offered for sale in this state, except as may be permitted in ~~37.7(3)"k"~~ *37.8(7)* and in 37.9(514D).

37.8(3) Benefit plans shall be uniform in structure, language, designation and format to the standard benefit plans "A" through ~~"J"~~ *"L"* listed in this ~~subrule~~ *rule* and conform to the definitions in 37.3(514D). Each benefit shall be structured in accordance with the format provided in 37.7(2), ~~and~~ 37.7(3), *37.7(4) and 37.7(5)* and list the benefits in the order

INSURANCE DIVISION[191](cont'd)

shown in this ~~subrule~~ *rule*. For purposes of this rule, "structure, language, and format" means style, arrangement and overall content of a benefit.

37.8(5) Makeup of benefit plans:

a. to g. No change.

h. Standardized Medicare supplement benefit plan "H" shall consist of only the following: The Core Benefit, as defined in 37.7(2), plus the Medicare Part A Deductible, Skilled Nursing Facility Care, Basic Prescription Drug Benefit and Medically Necessary Emergency Care in a Foreign Country as defined in 37.7(3) "a," "b," "f," and "h," respectively. *The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005.*

i. Standardized Medicare supplement benefit plan "I" shall consist of only the following: The Core Benefit, as defined in 37.7(2), plus the Medicare Part A Deductible, Skilled Nursing Facility Care, 100 Percent of the Medicare Part B Excess Charges, Basic Prescription Drug Benefit, Medically Necessary Emergency Care in a Foreign Country and At-Home Recovery Benefit as defined in 37.7(3)"a," "b," "e," "f," "h," and "j," respectively. *The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005.*

j. Standardized Medicare supplement benefit plan "J" shall consist of only the following: The Core Benefit, as defined in 37.7(2), plus the Medicare Part A Deductible, Skilled Nursing Facility Care, Medicare Part B Deductible, 100 Percent of the Medicare Part B Excess Charges, Extended Prescription Drug Benefit, Medically Necessary Emergency Care in a Foreign Country, Preventive Medical Care and At-Home Recovery Benefit as defined in 37.7(3)"a," "b," "c," "e," "g," "h," "i," and "j," respectively. *The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005.*

k. No change.

l. Standardized Medicare supplement benefit high deductible plan "J" shall consist only of the following: 100 percent of covered expenses following the payment of the annual high deductible plan "J" deductible. The covered expenses include the Core Benefit as defined in 37.7(2), plus the Medicare Part A deductible, Skilled Nursing Facility Care, Medicare Part B deductible, 100 percent of the Medicare Part B Excess Charges, Extended Outpatient Prescription Drug Benefit, Medically Necessary Emergency Care in a Foreign Country, Preventive Medical Care Benefit and At-Home Recovery Benefit as defined in 37.7(3)"a," "b," "c," "e," "g," "h," "i," and "j," respectively. The annual high deductible plan "J" deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement plan "J" policy, and shall be in addition to any other specific benefit deductibles. The annual deductible shall be $1,500 for 1998 and 1999, and shall be based on a calendar year. It shall be adjusted annually thereafter by the Secretary to reflect the change in the consumer price index for all urban consumers for the 12-month period ending with August of the preceding year, and rounded to the nearest multiple of $10. *The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005.*

Adopt the following **new** subrules:

37.8(6) Standardized Medicare supplement benefit plan "K" mandated by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 shall consist of only those benefits described in subrule 37.7(4). Standardized Medicare supplement benefit plan "L" mandated by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 shall consist of only those benefits described in subrule 37.7(5).

37.8(7) New or Innovative Benefits: An issuer may, with the prior approval of the commissioner, offer policies or certificates with new or innovative benefits in addition to the benefits provided in a policy or certificate that otherwise complies with the applicable standards. The new or innovative benefits may include benefits that are appropriate to Medicare supplement insurance, new or innovative, not otherwise available, cost-effective, and offered in a manner which is consistent with the goal of simplification of Medicare supplement policies. After December 31, 2005, the innovative benefit shall not include an outpatient prescription drug benefit.

ITEM 11. Amend rule 191—37.9(514D) as follows:

Amend paragraph **37.9(9)"c"** as follows:

c. A description of the restricted network provisions, including payments for coinsurance and deductibles, when providers other than network providers are utilized. *Except to the extent specified in the policy or certificate, expenses incurred when using out-of-network providers do not count toward the out-of-pocket annual limit contained in plans "K" and "L."*

Amend paragraph **37.9(13)"b"** as follows:

b. For the purposes of this subrule, a Medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the Medicare Select policy or certificate being replaced. For the purposes of this paragraph, a significant benefit means coverage for the Medicare Part A deductible, ~~coverage for prescription drugs,~~ coverage for at-home recovery services or coverage for Part B excess charges.

Amend paragraph **37.9(14)"b"** as follows:

b. For the purposes of this subrule, a Medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the Medicare Select policy or certificate being replaced. For the purposes of this paragraph, a significant benefit means coverage for the Medicare Part A deductible, ~~coverage for prescription drugs,~~ coverage for at-home recovery services or coverage for Part B excess charges.

ITEM 12. Amend subrule 37.10(3) as follows:

37.10(3) Except as provided in 37.21(514D) *or 37.24(514D)*, subrule 37.10(1) shall not be construed as preventing the exclusion of benefits under a policy, during the first six months, based on a preexisting condition for which the policyholder or certificate holder received treatment or was otherwise diagnosed during the six months before the coverage became effective.

ITEM 13. Amend subparagraph **37.12(1)"a"(2)** as follows:

(2) At least 65 percent of the aggregate amount of premiums earned in the case of individual policies, calculated on the basis of incurred claims experience or incurred health care expenses where coverage is provided by a health maintenance organization on a service rather than reimbursement basis and earned premiums for such period and in accordance with accepted actuarial principles and practices. *Incurred health care expenses where coverage is provided by a health maintenance organization shall not include:*

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1. *Home office and overhead costs;*
2. *Advertising costs;*
3. *Commissions and other acquisition costs;*
4. *Taxes;*
5. *Capital costs;*
6. *Administrative costs; and*
7. *Claims processing costs.*

ITEM 14. Renumber subrules **37.13(2)** to **37.13(5)** as **37.13(3)** to **37.13(6)** and adopt **new** subrule 37.13(2) as follows:

37.13(2) An issuer shall file any riders or amendments to policy or certificate forms to delete outpatient prescription drug benefits as required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 only with the commissioner in the state in which the policy or certificate was issued.

ITEM 15. Amend rule 191—37.15(514D) as follows:

Amend subparagraph **37.15(1)"f"(1)** as follows:

(1) Issuers of accident and sickness policies, or certificates which provide hospital or medical expense coverage on an expense-incurred or indemnity basis to a person(s) eligible for Medicare shall provide to those applicants a Guide to Health Insurance for People with Medicare in the form developed jointly by the National Association of Insurance Commissioners and ~~the Health Care Financing Administration~~ *CMS* and in a type size no smaller than 12-point type. Delivery of the Guide shall be made whether or not such policies or certificates are advertised, solicited or issued as Medicare supplement policies or certificates as defined in this chapter. Except in the case of direct response issuers, delivery of the Guide shall be made to the applicant at the time of application and acknowledgment of receipt of the Guide shall be obtained by the issuer. Direct response issuers shall deliver the Guide to the applicant upon request but not later than at the time the policy is delivered.

Renumber subrules **37.15(3)** and **37.15(4)** as **37.15(4)** and **37.15(5)** and adopt **new** subrule 37.15(3) as follows:

37.15(3) MMA notice requirements. Issuers shall comply with any notice requirements of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

Amend renumbered subrule **37.15(4)**, paragraph **"c,"** as follows:

c. The outline of coverage provided to applicants pursuant to this subrule consists of four parts: a cover page, premium information, disclosure pages, and charts displaying the features of each benefit plan offered by the issuer. The outline of coverage shall be in the language and format prescribed below in no less than 12-point type. All plans "A" to ~~"J"~~ *"L"* shall be shown on the cover page, and the plan(s) that ~~are~~ *is* offered by the issuer shall be prominently identified. Premium information for plans that are offered shall be shown on the cover page or immediately following the cover page and shall be prominently displayed. The premium and mode shall be stated for all plans that are offered to the prospective applicant. All possible premiums for the prospective applicant shall be illustrated.

ITEM 16. Rescind subrule **37.15(4)**, paragraph **"d,"** and adopt the following **new** paragraph **"d"** in lieu thereof:

d. The following items shall be included in the outline of coverage in the order prescribed below.

[COMPANY NAME]
Outline of Medicare Supplement Coverage−Cover Page: 1 of 2

Benefit Plans _____ [insert letters of plans being offered]

These charts show the benefits included in each of the standard Medicare supplement plans. Every company must make available Plan "A." Some plans may not be available in your state.

See Outlines of Coverage sections for details about ALL plans

Basic Benefits for Plans A − J:
Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
Medical Expenses: Part B coinsurance (generally 20% of Medicare-approved expenses) or copayments for hospital outpatient services.
Blood: First three pints of blood each year.

A	B	C	D	E	F	F*	G	H	I	J	J*
Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits		Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible		Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	
		Part B Deductible			Part B Deductible					Part B Deductible	
					Part B Excess (100%)		Part B Excess (80%)		Part B Excess (100%)	Part B Excess (100%)	
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	

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A	B	C	D	E	F	F*	G	H	I	J	J*
			At-Home Recovery				At-Home Recovery		At-Home Recovery	At-Home Recovery	
				Preventive Care NOT covered by Medicare						Preventive Care NOT covered by Medicare	

* Plans F and J also have an option called a high deductible Plan F and a high deductible Plan J. These high deductible plans pay the same benefits as Plans F and J after one has paid a calendar year [$1690] deductible. Benefits from high deductible Plans F and J will not begin until out-of-pocket expenses exceed [$1690]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

[COMPANY NAME]
Outline of Medicare Supplement Coverage−Cover Page: 2 of 2

Basic Benefits for Plans K and L include similar services as Plans A − J but cost sharing for the basic benefits is at different levels.

J	K**	L**
Basic Benefits	100% of Part A hospitalization coinsurance plus coverage for 365 days after Medicare benefits end 50% Hospice cost sharing 50% of Medicare eligible expenses for the first three pints of blood 50% Part B coinsurance, except 100% coinsurance for Part B preventive services	100% of Part A hospitalization coinsurance plus coverage for 365 days after Medicare benefits end 75% Hospice cost sharing 75% of Medicare eligible expenses for the first three pints of blood 75% Part B coinsurance, except 100% coinsurance for Part B preventive services
Skilled Nursing Facility Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance
Part A Deductible	50% Part A Deductible	75% Part A Deductible
Part B Deductible		
Part B Excess (100%)		
Foreign Travel Emergency		
At-Home Recovery		
Preventive Care NOT covered by Medicare		
	$[4000] Out-of-Pocket Annual Limit***	$[2000] Out-of-Pocket Annual Limit***

** Plans K and L provide for different cost sharing for items and services than Plans A − J.
Once you reach the annual limit, the plan pays 100% of the Medicare copayments, coinsurance, and deductibles for the rest of the calendar year. The out-of-pocket annual limit does NOT include charges from your provider that exceed Medicare-approved amounts, called "Excess Charges." You will be responsible for paying excess charges.

*** The out-of-pocket annual limit will increase each year for inflation.

See Outlines of Coverage for details and exceptions.

PREMIUM INFORMATION

We [insert issuer's name] can only raise your premium if we raise the premium for all policies like yours in this State. [If the premium is based on the increasing age of the insured, include information specifying when premiums will change.]

DISCLOSURES

Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

RIGHT TO RETURN POLICY

If you find that you are not satisfied with your policy, you may return it to [insert issuer's address]. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

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POLICY REPLACEMENT

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

NOTICE

This policy may not fully cover all of your medical costs.
[for agents:]
Neither [insert company's name] nor its agents are connected with Medicare.
[for direct response:]
[Insert company's name] is not connected with Medicare.
This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security office or consult "Medicare and You" for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information. [If the policy or certificate is guaranteed issue, this paragraph need not appear.]

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

[Include for each plan prominently identified in the cover page a chart showing the services, Medicare payments, plan payments and insured payments for each plan, using the same language, in the same order, using uniform layout and format as shown in the charts below. No more than four plans may be shown on one chart. For purposes of illustration, charts for each plan are included in this subrule. An issuer may use additional benefit plan descriptions on these charts pursuant to 37.8(4).]

[Include an explanation of any innovative benefits on the cover page and in the chart, in a manner approved by the commissioner.]

PLAN A

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[876]	$0	$[876] (Part A deductible)
61st through 90th day	All but $[219] a day	$[219] a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but $[438] a day	$[438] a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare eligible expenses	$0**
—Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $[109.50] a day	$0	Up to $[109.50] a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

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MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

* Once you have been billed $[100] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[100] of Medicare-Approved Amounts*	$0	$0	$[100] (Part B deductible)
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $[100] of Medicare-Approved Amounts*	$0	$0	$[100] (Part B deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment			
First $[100] of Medicare-Approved Amounts*	$0	$0	$[100] (Part B deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0

PLAN B

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[876]	$[876] (Part A deductible)	$0
61st through 90th day	All but $[219] a day	$[219] a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but $[438] a day	$[438] a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare eligible expenses	$0**
—Beyond the additional 365 days	$0	$0	All costs

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SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $[109.50] a day	$0	Up to $[109.50] a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

* Once you have been billed $[100] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[100] of Medicare-Approved Amounts*	$0	$0	$[100] (Part B deductible)
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $[100] of Medicare-Approved Amounts*	$0	$0	$[100] (Part B deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment			
First $[100] of Medicare-Approved Amounts*	$0	$0	$[100] (Part B deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0

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PLAN C

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[876]	$[876] (Part A deductible)	$0
61st through 90th day	All but $[219] a day	$[219] a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but $[438] a day	$[438] a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare eligible expenses	$0**
—Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $[109.50] a day	Up to $[109.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

* Once you have been billed $[100] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[100] of Medicare-Approved Amounts*	$0	$[100] (Part B deductible)	$0
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $[100] of Medicare-Approved Amounts*	$0	$[100] (Part B deductible)	$0
Remainder of Medicare-Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

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PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment			
First $[100] of Medicare-Approved Amounts*	$0	$[100] (Part B deductible)	$0
Remainder of Medicare-Approved Amounts	80%	20%	$0

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL—NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN D

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[876]	$[876] (Part A deductible)	$0
61st through 90th day	All but $[219] a day	$[219] a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but $[438] a day	$[438] a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare eligible expenses	$0**
—Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $[109.50] a day	Up to $[109.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

INSURANCE DIVISION[191](cont'd)

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

* Once you have been billed $[100] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[100] of Medicare-Approved Amounts*	$0	$0	$[100] (Part B deductible)
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $[100] of Medicare-Approved Amounts*	$0	$0	$[100] (Part B deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment			
First $[100] of Medicare-Approved Amounts*	$0	$0	$[100] (Part B deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0
AT-HOME RECOVERY SERVICES—NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
—Benefit for each visit	$0	Actual charges to $40 a visit	Balance
—Number of visits covered (must be received within 8 weeks of last Medicare-Approved visit)	$0	Up to the number of Medicare-Approved visits, not to exceed 7 each week	
—Calendar year maximum	$0	$1,600	

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL—NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

INSURANCE DIVISION[191](cont'd)

PLAN E

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[876]	$[876] (Part A deductible)	$0
61st through 90th day	All but $[219] a day	$[219] a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but $[438] a day	$[438] a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare eligible expenses	$0**
—Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $[109.50] a day	Up to $[109.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

MEDICARE (PART B)—MEDICAL SERVICES—PER BENEFIT PERIOD

* Once you have been billed $[100] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[100] of Medicare-Approved Amounts*	$0	$0	$[100] (Part B deductible)
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $[100] of Medicare-Approved Amounts*	$0	$0	$[100] (Part B deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0

INSURANCE DIVISION[191](cont'd)

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment First $[100] of Medicare-Approved Amounts*	$0	$0	$[100] (Part B deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL—NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum
***PREVENTIVE MEDICAL CARE BENEFIT—NOT COVERED BY MEDICARE** Some annual physical and preventive tests and services administered or ordered by your doctor when not covered by Medicare			
First $120 each calendar year	$0	$120	$0
Additional charges	$0	$0	All costs

*Medicare benefits are subject to change. Please consult the latest Guide to Health Insurance for People with Medicare.

PLAN F or HIGH DEDUCTIBLE PLAN F

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

[**This high deductible plan pays the same benefits as Plan F after you have paid a calendar year [$1690] deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are [$1690]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.]

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[1690] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[1690] DEDUCTIBLE,**] YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[876]	$[876] (Part A deductible)	$0
61st through 90th day	All but $[219] a day	$[219] a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but $[438] a day	$[438] a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare eligible expenses	$0***
—Beyond the additional 365 days	$0	$0	All costs

INSURANCE DIVISION[191](cont'd)

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[1690] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[1690] DEDUCTIBLE,**] YOU PAY
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $[109.50] a day	Up to $[109.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

*** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

*Once you have been billed $[100] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

[**This high deductible plan pays the same benefits as Plan F after you have paid a calendar year [$1690] deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are [$1690]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.]

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[1690] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[1690] DEDUCTIBLE,**] YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[100] of Medicare-Approved Amounts*	$0	$[100] (Part B deductible)	$0
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-Approved Amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $[100] of Medicare-Approved Amounts*	$0	$[100] (Part B deductible)	$0
Remainder of Medicare-Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

INSURANCE DIVISION[191](cont'd)

PARTS A & B

SERVICES	MEDICARE PAYS	AFTER YOU PAY $[1690] DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO $[1690] DEDUCTIBLE,** YOU PAY
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment			
First $[100] of Medicare-Approved Amounts*	$0	$[100] (Part B deductible)	$0
Remainder of Medicare-Approved Amounts	80%	20%	$0

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY $[1690] DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO $[1690] DEDUCTIBLE,** YOU PAY
FOREIGN TRAVEL—NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN G

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[876]	$[876] (Part A deductible)	$0
61st through 90th day	All but $[219] a day	$[219] a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but $[438] a day	$[438] a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare eligible expenses	$0**
—Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $[109.50] a day	Up to $[109.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0

INSURANCE DIVISION[191](cont'd)

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

* Once you have been billed $[100] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[100] of Medicare-Approved Amounts*	$0	$0	$[100] (Part B deductible)
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-Approved Amounts)	$0	80%	20%
BLOOD			
First 3 pints	$0	All costs	$0
Next $[100] of Medicare-Approved Amounts*	$0	$0	$[100] (Part B deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment			
First $[100] of Medicare-Approved Amounts*	$0	$0	$[100] (Part B deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0
AT-HOME RECOVERY SERVICES—NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
—Benefit for each visit	$0	Actual charges to $40 a visit	Balance
—Number of visits covered (must be received within 8 weeks of last Medicare-Approved visit)	$0	Up to the number of Medicare-Approved visits, not to exceed 7 each week	
—Calendar year maximum	$0	$1,600	

INSURANCE DIVISION[191](cont'd)

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL—NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN H

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[876]	$[876] (Part A deductible)	$0
61st through 90th day	All but $[219] a day	$[219] a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but $[438] a day	$[438] a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare eligible expenses	$0**
—Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $[109.50] a day	Up to $[109.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance

** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

INSURANCE DIVISION[191](cont'd)

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

* Once you have been billed $[100] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[100] of Medicare-Approved Amounts*	$0	$0	$[100] (Part B deductible)
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-Approved Amounts)	$0	0%	All Costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $[100] of Medicare-Approved Amounts*	$0	$0	$[100] (Part B deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment			
First $[100] of Medicare-Approved Amounts*	$0	$0	$[100] (Part B deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL—NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN I

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[876]	$[876] (Part A deductible)	$0
61st through 90th day	All but $[219] a day	$[219] a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but $[438] a day	$[438] a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare eligible expenses	$0**
—Beyond the additional 365 days	$0	$0	All costs

INSURANCE DIVISION[191](cont'd)

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $[109.50] a day	Up to $[109.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

* Once you have been billed $[100] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[100] of Medicare-Approved Amounts*	$0	$0	$[100] (Part B deductible)
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-Approved Amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $[100] of Medicare-Approved Amounts*	$0	$0	$[100] (Part B deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment			
First $[100] of Medicare-Approved Amounts*	$0	$0	$[100] (Part B deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0
AT-HOME RECOVERY SERVICES—NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			

INSURANCE DIVISION[191](cont'd)

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
—Benefit for each visit	$0	Actual charges to $40 a visit	Balance
—Number of visits covered (must be received within 8 weeks of last Medicare-Approved visit)	$0	Up to the number of Medicare-Approved visits, not to exceed 7 each week	
—Calendar year maximum	$0	$1,600	

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL—NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN J or HIGH DEDUCTIBLE PLAN J

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

[** This high deductible plan pays the same benefits as Plan J after you have paid a calendar year [$1690] deductible. Benefits from high deductible Plan J will not begin until out-of-pocket expenses are [$1690]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate outpatient prescription drug deductible or the plan's separate foreign travel emergency deductible.]

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[1690] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[1690] DEDUCTIBLE,**] YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[876]	$[876] (Part A deductible)	$0
61st through 90th day	All but $[219] a day	$[219] a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but $[438] a day	$[438] a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare eligible expenses	$0***
—Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $[109.50] a day	Up to $[109.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0

*** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

INSURANCE DIVISION[191](cont'd)

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

* Once you have been billed $[100] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

[**This high deductible plan pays the same benefits as Plan J after you have paid a calendar year [$1690] deductible. Benefits from high deductible Plan J will not begin until out-of-pocket expenses are [$1690]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate prescription drug deductible or the plan's separate foreign travel emergency deductible.]

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[1690] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[1690] DEDUCTIBLE,**] YOU PAY
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[100] of Medicare-Approved Amounts*	$0	$[100] (Part B deductible)	$0
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-Approved Amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $[100] of Medicare-Approved Amounts*	$0	$[100] (Part B deductible)	$0
Remainder of Medicare-Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	AFTER YOU PAY $[1690] DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO $[1690] DEDUCTIBLE,** YOU PAY
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment			
First $[100] of Medicare-Approved Amounts*	$0	$[100] (Part B deductible)	$0
Remainder of Medicare-Approved Amounts	80%	20%	$0
AT-HOME RECOVERY SERVICES—NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
—Benefit for each visit	$0	Actual charges to $40 a visit	Balance
—Number of visits covered (must be received within 8 weeks of last Medicare-Approved visit)	$0	Up to the number of Medicare-Approved visits, not to exceed 7 each week	
—Calendar year maximum	$0	$1,600	

INSURANCE DIVISION[191](cont'd)

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY $[1690] DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO $[1690] DEDUCTIBLE,** YOU PAY
FOREIGN TRAVEL—NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum
***PREVENTIVE MEDICAL CARE BENEFIT—NOT COVERED BY MEDICARE** Some annual physical and preventive tests and services administered or ordered by your doctor when not covered by Medicare			
First $120 each calendar year	$0	$120	$0
Additional charges	$0	$0	All costs

***Medicare benefits are subject to change. Please consult the latest Guide to Health Insurance for People with Medicare.

PLAN K

*You will pay half the cost sharing of some covered services until you reach the annual out-of-pocket maximum of $[4,000] each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart below. Once you reach the annual maximum, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

** A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOSPITALIZATION** Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[876]	$[438] (50% of Part A deductible)	$[438] (50% of Part A deductible)♦
61st through 90th day	All but $[219] a day	$[219] a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but $[438] a day	$[438] a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare eligible expenses	$0***
—Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE** You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $[109.50] a day	Up to $[54.75] a day	Up to $[54.75] a day ♦
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	50%	50%♦
Additional amounts	100%	$0	$0

INSURANCE DIVISION[191](cont'd)

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	Generally, most Medicare eligible expenses for outpatient drugs and inpatient respite care	50% of coinsurance or copayments	50% of coinsurance or copayments♦

*** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

**** Once you have been billed $[100] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[100] of Medicare-Approved Amounts****	$0	$0	$[100] (Part B deductible)**** ♦
Preventive Benefits for Medicare-covered services	75% or more of Medicare-Approved Amounts	Remainder of Medicare-Approved Amounts	All costs above Medicare-Approved Amounts
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 10%	Generally 10% ♦
Part B Excess Charges (Above Medicare-Approved Amounts)	$0	$0	All costs (and they do not count toward annual out-of-pocket limit of [$4,000])*
BLOOD			
First 3 pints	$0	50%	50%♦
Next $[100] of Medicare-Approved Amounts****	$0	$0	$[100] (Part B deductible)**** ♦
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 10%	Generally 10% ♦
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

* This plan limits your annual out-of-pocket payments for Medicare-approved amounts to $[4,000] per year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment First $[100] of Medicare-Approved Amounts*****	$0	$0	$[100] (Part B deductible) ♦
Remainder of Medicare-Approved Amounts	80%	10%	10%♦

*****Medicare benefits are subject to change. Please consult the latest Guide to Health Insurance for People with Medicare.

INSURANCE DIVISION[191](cont'd)

PLAN L

*You will pay one-fourth of the cost sharing of some covered services until you reach the annual out-of-pocket maximum of $[2,000] each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart below. Once you reach the annual maximum, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

** A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOSPITALIZATION** Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[876]	$[657] (75% of Part A deductible)	$[219] (25% of Part A deductible)♦
61st through 90th day	All but $[219] a day	$[219] a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but $[438] a day	$[438] a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare eligible expenses	$0***
—Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE** You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $[109.50] a day	Up to $[82.13] a day	Up to $[27.37] a day♦
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	75%	25%♦
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	Generally, most Medicare eligible expenses for outpatient drugs and inpatient respite care	75% of coinsurance	25% of coinsurance♦

*** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

INSURANCE DIVISION[191](cont'd)

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

**** Once you have been billed $[100] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[100] of Medicare-Approved Amounts****	$0	$0	$[100] (Part B deductible)**** ♦
Preventive Benefits for Medicare-covered services	Generally 75% or more of Medicare-Approved Amounts	Remainder of Medicare-Approved Amounts	All costs above Medicare-Approved Amounts
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 15%	Generally 5% ♦
Part B Excess Charges (Above Medicare-Approved Amounts)	$0	$0	All costs (and they do not count toward annual out-of-pocket limit of [$2,000])*
BLOOD			
First 3 pints	$0	75%	25%♦
Next $[100] of Medicare-Approved Amounts****	$0	$0	$[100] (Part B deductible) ♦
Remainder of Medicare-Approved Amounts	80%	15%	5%♦
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

* This plan limits your annual out-of-pocket payments for Medicare-approved amounts to $[2,000] per year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment First $[100] of Medicare-Approved Amounts*****	$0	$0	$[100] (Part B deductible) ♦
Remainder of Medicare-Approved Amounts	80%	15%	5% ♦

***** Medicare benefits are subject to change. Please consult the latest Guide to Health Insurance for People with Medicare.

ITEM 17. Amend subrule 37.16(1) as follows:

Amend the introductory paragraph as follows:

37.16(1) Application forms shall include the following questions designed to elicit information as to whether, as of the date of the application, the applicant *currently* has ~~another~~ Medicare supplement ~~or other~~ , *Medicare Advantage*, *Medicaid coverage or another* health insurance policy or certificate in force or whether a Medicare supplement policy or certificate is intended to replace any other accident and sickness policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and agent containing such questions and statements may be used.

Amend paragraph **"a"** by rescinding subparagraph **(4)**, renumbering subparagraph **(5)** as **(6)**, and adopting **new** subparagraphs **(4)** and **(5)** as follows:

(4) If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing Medicaid eligibility. If the Medicare supplement policy provided coverage for prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

(5) If you are eligible for, and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing your employer or union-based group health

INSURANCE DIVISION[191](cont'd)

plan. If the Medicare supplement policy provided coverage for prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

Rescind paragraph **"b"** and adopt the following **new** paragraph **"b"** in lieu thereof:

b. Questions.

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare supplement plans. Please include a copy of the notice from your prior insurer with your application. PLEASE ANSWER ALL QUESTIONS.

(Please mark Yes or No below with an "X".)

To the best of your knowledge,

(1) (a) Did you turn age 65 in the last 6 months?
Yes____No____

(b) Did you enroll in Medicare Part B in the last 6 months?
Yes____No____

(c) If yes, what is the effective date? _____

(2) Are you covered for medical assistance through the state Medicaid program?
(NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer NO to this question.)
Yes____No____

If yes,

(a) Will Medicaid pay your premiums for this Medicare supplement policy?
Yes____No____

(b) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?
Yes____No____

(3) (a) If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank.
START __/__/__ END __/__/__

(b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy?
Yes____No____

(c) Was this your first time in this type of Medicare plan?
Yes____No____

(d) Did you drop a Medicare supplement policy to enroll in this plan?
Yes____No____

(4) (a) Do you have another Medicare supplement policy in force?
Yes____No____

(b) If so, with what company, and what plan do you have [optional for Direct Mailers]?
_____

(c) If so, do you intend to replace your current Medicare supplement policy with this policy?
Yes____No____

(5) Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan)
Yes____No____

(a) If so, with what company and what kind of policy?
_____
_____
_____
_____

(b) What are your dates of coverage under the other policy?
START __/__/__ END __/__/__
(If you are still covered under the other policy, leave "END" blank.)

INSURANCE DIVISION[191](cont'd)

ITEM 18. Rescind subrule 37.16(5) and adopt the following **new** subrules 37.16(5) and 37.16(6):

37.16(5) The notice required by subrule 37.16(4) for an issuer shall be provided in substantially the following form in no less than 12-point type:

NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE OR MEDICARE ADVANTAGE

[Insurance company's name and address]

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to [your application] [information you have furnished], you intend to terminate existing Medicare supplement or Medicare Advantage insurance and replace it with a policy to be issued by [Company Name] Insurance Company. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision, you should terminate your present Medicare supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY ISSUER, AGENT [BROKER OR OTHER REPRESENTATIVE]:

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare supplement policy will not duplicate your existing Medicare supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare supplement coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reason (check one):

____ Additional benefits.
____ No change in benefits, but lower premiums.
____ Fewer benefits and lower premiums.
____ My plan has outpatient prescription drug coverage and I am enrolling in Part D.
____ Disenrollment from a Medicare Advantage Plan. Please explain reason for disenrollment. [optional only for Direct Mailers]
____ Other. (Please specify.) _____

1. **Note:** If the issuer of the Medicare supplement policy being applied for does not, or is otherwise prohibited from imposing preexisting condition limitations, please skip to statement 2 below. Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. State law provides that your replacement policy or certificate may not contain new preexisting conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

3. If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded. [If the policy or certificate is guaranteed issue, this paragraph need not appear.]

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

_____
(Signature of Agent, Broker or Other Representative)*
[Typed Name and Address of Issuer, Agent or Broker]

_____
(Applicant's Signature)

_____
(Date)
*Signature not required for direct response sales.

INSURANCE DIVISION[191](cont'd)

37.16(6) Statements 1 and 2 of the replacement notice (applicable to preexisting conditions) may be deleted by an issuer if the replacement does not involve application of a new preexisting condition limitation.

ITEM 19. Amend rule 191—37.19(514D) as follows:

191—37.19(514D) Appropriateness of recommended purchase and excessive insurance.

37.19(1) No change.

37.19(2) Any sale of *a* Medicare supplement ~~coverage~~ *policy or certificate* that will provide an individual more than one Medicare supplement policy or certificate is prohibited.

37.19(3) *An issuer shall not issue a Medicare supplement policy or certificate to an individual enrolled in Medicare Part C unless the effective date of the coverage is after the termination date of the individual's Part C coverage.*

ITEM 20. Amend rule 191—37.24(514D) as follows:

Amend subrule 37.24(1), introductory paragraph, as follows:

37.24(1) Eligible persons are those individuals described in subrule 37.24(2) who seek to enroll under the policy during the period specified in subrule 37.24(3) and who submit evidence of the date of termination, ~~or~~ disenrollment, *or Medicare Part D enrollment* with the application for a Medicare supplement policy.

Amend subrule **37.24(2)** as follows:

Amend paragraph **"c,"** subparagraph **(3)**, as follows:

(3) An organization operating under an agreement under Section 1833(a)(1)(A) of the Social Security Act (health care ~~payment~~ *prepayment* plan); or

Adopt the following **new** paragraph **"g"**:

g. The individual enrolls in a Medicare Part D plan during the initial enrollment period and, at the time of enrollment in Part D, was enrolled under a Medicare supplement policy that covers outpatient prescription drugs and the individual terminates enrollment in the Medicare supplement policy and submits evidence of enrollment in Medicare Part D along with the application for a policy described in paragraph 37.24(5)"e."

Amend subrule **37.24(3)** as follows:

Amend paragraph **"a"** as follows:

a. In the case of an individual described in paragraph 37.24(2)"a," the guaranteed issue period begins on the *later of: (1) the* date the individual receives a notice of termination or cessation of some or all supplemental health benefits (or, if a notice is not received, notice that a claim has been denied because of such a termination or cessation)*; or (2) the date that the applicable coverage terminates or ceases;* and ends 63 days ~~after the date of the applicable notice~~ *thereafter.*

Reletter paragraph **"e"** as **"f"** and adopt the following **new** paragraph **"e"**:

e. In the case of an individual described in paragraph 37.24(2)"g," the guaranteed issue period begins on the date the individual receives notice pursuant to Section 1882(v)(2)(B) of the Social Security Act from the Medicare supplement issuer during the 60-day period immediately preceding the initial Part D enrollment period and ends on the date that is 63 days after the effective date of the individual's coverage under Medicare Part D; and

Amend subrule 37.24(5) as follows:

37.24(5) Products to which eligible persons are entitled. The Medicare supplement policy to which eligible persons are entitled under:

a. Subrule 37.24(2), paragraphs "a," "b," "c," and "d," is a Medicare supplement policy which has a benefit package classified as Plan A, B, C, ~~or~~ F *(including F with a high deductible), K or L* offered by any issuer.

b. ~~Paragraph~~ *Subject to paragraph 37.24(5)"c," paragraph* 37.24(2)"e" is the same Medicare supplement policy in which the individual was most recently previously enrolled if available from the same issuer, or, if not so available, a policy described in paragraph 37.24(5)"a."

c. After December 31, 2005, if the individual was most recently enrolled in a Medicare supplement policy with an outpatient prescription drug benefit, a Medicare supplement policy described in this paragraph is:

(1) The policy available from the same issuer but modified to remove outpatient prescription drug coverage; or

(2) At the election of the policyholder, an A, B, C, F (including F with a high deductible), K or L policy that is offered by any issuer.

~~c~~ *d.* Paragraph 37.24(2)"f" shall include any Medicare supplement policy offered by any issuer.

e. Paragraph 37.24(2)"g" is a Medicare supplement policy that has a benefit package classified as Plan A, B, C, F (including F with a high deductible), K or L, and that is offered and is available for issuance to new enrollees by the same issuer that issued the individual's Medicare supplement policy with outpatient prescription drug coverage.

INSURANCE DIVISION[191](cont'd)

ITEM 21. Rescind **191—Chapter 37**, **Appendix A**, and adopt the following **new** appendix in lieu thereof:

APPENDIX A

MEDICARE SUPPLEMENT REFUND CALCULATION FORM
FOR CALENDAR YEAR _____

TYPE[1] _____ SMSBP[2] _____
For the State of _____ Company Name _____
NAIC Group Code _____ NAIC Company Code _____
Address _____ Person Completing Exhibit _____
Title _____ Telephone Number _____

Line		(a) Earned Premium[3]	(b) Incurred Claims[4]
1.	Current Year's Experience		
	a. Total (all policy years)		
	b. Current year's issues[5]		
	c. Net (for reporting purposes = 1a − 1b)		
2.	Past Years' Experience (all policy years)		
3.	Total Experience (Net Current Year + Past Year)		

4.	Refunds Last Year (Excluding Interest)	
5.	Previous Since Inception (Excluding Interest)	
6.	Refunds Since Inception (Excluding Interest)	
7.	Benchmark Ratio Since Inception (see worksheet for Ratio 1)	
8.	Experienced Ratio Since Inception (Ratio 2) Total Actual Incurred Claims (line 3, col. b) Total Earned Prem. (line 3, col. a) − Refunds Since Inception (line 6)	
9.	Life Years Exposed Since Inception If the Experienced Ratio is less than the Benchmark Ratio, and there are more than 500 life years exposure, then proceed to calculation of refund.	
10.	Tolerance Permitted (obtained from credibility table)	

Medicare Supplement Credibility Table

Life Years Exposed Since Inception	Tolerance
10,000 +	0.0%
5,000 - 9,999	5.0%
2,500 - 4,999	7.5%
1,000 - 2,499	10.0%
500 - 999	15.0%
If less than 500, no credibility.	

1 Individual, Group, Individual Medicare Select, or Group Medicare Select only.
2 "SMSBP" = Standardized Medicare Supplement Benefit Plan - Use "P" for prestandardized plans.
3 Includes Modal Loadings and Fees Charged.
4 Excludes Active Life Reserves.
5 This is to be used as "Issue Year Earned Premium" for Year 1 of next year's "Worksheet for Calculation of Benchmark Ratios."

INSURANCE DIVISION[191](cont'd)

MEDICARE SUPPLEMENT REFUND CALCULATION FORM
FOR CALENDAR YEAR _____

TYPE[1] _____ SMSBP[2] _____
For the State of _____ Company Name _____
NAIC Group Code _____ NAIC Company Code _____
Address _____ Person Completing Exhibit _____
Title _____ Telephone Number _____

11.	Adjustment to Incurred Claims for Credibility Ratio 3 = Ratio 2 + Tolerance	

If Ratio 3 is more than Benchmark Ratio (Ratio 1), a refund or credit to premium is not required.
If Ratio 3 is less than the Benchmark Ratio, then proceed.

12.	Adjusted Incurred Claims [Total Earned Premiums (line 3, col. a) − Refunds Since Inception (line 6)] × Ratio 3 (line 11)	
13.	Refund = Total Earned Premiums (line 3, col. a) − Refunds Since Inception (line 6) − [Adjusted Incurred Claims (line 12) / Benchmark Ratio (Ratio 1)]	

If the amount on line 13 is less than .005 times the annualized premium in force as of December 31 of the reporting year, then no refund is made. Otherwise, the amount on line 13 is to be refunded or credited, and a description of the refund or credit against premiums to be used must be attached to this form.

I certify that the above information and calculations are true and accurate to the best of my knowledge and belief.

_____
Signature

_____
Name (Please type.)

_____
Title (Please type.)

_____
Date

[1] Individual, Group, Individual Medicare Select, or Group Medicare Select only.
[2] "SMSBP" = Standardized Medicare Supplement Benefit Plan − Use "P" for prestandardized plans.

REPORTING FORM FOR THE CALCULATION OF
BENCHMARK RATIO SINCE INCEPTION FOR GROUP POLICIES
FOR CALENDAR YEAR _____

TYPE[1] _____ SMSBP[2] _____
For the State of _____ Company Name _____
NAIC Group Code _____ NAIC Company Code _____
Address _____ Person Completing Exhibit _____
Title _____ Telephone Number _____

(a)[3]	(b)[4]	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(o)[5]
Year	Earned Premium	Factor	(b)×(c)	Cumulative Loss Ratio	(d)×(e)	Factor	(b)×(g)	Cumulative Loss Ratio	(h)×(i)	Policy Year Loss Ratio
1		2.770		0.507		0.000		0.000		0.46
2		4.175		0.567		0.000		0.000		0.63
3		4.175		0.567		1.194		0.759		0.75
4		4.175		0.567		2.245		0.771		0.77
5		4.175		0.567		3.170		0.782		0.80
6		4.175		0.567		3.998		0.792		0.82
7		4.175		0.567		4.754		0.802		0.84
8		4.175		0.567		5.445		0.811		0.87
9		4.175		0.567		6.075		0.818		0.88
10		4.175		0.567		6.650		0.824		0.88

INSURANCE DIVISION[191](cont'd)

(a)[3]	(b)[4]	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(o)[5]
11		4.175		0.567		7.176		0.828		0.88
12		4.175		0.567		7.655		0.831		0.88
13		4.175		0.567		8.093		0.834		0.89
14		4.175		0.567		8.493		0.837		0.89
15+[6]		4.175		0.567		8.684		0.838		0.89
Total:			(k):		(l):		(m):		(n):	

Benchmark Ratio Since Inception: (l + n)/(k + m): _____

1 Individual, Group, Individual Medicare Select, or Group Medicare Select only.
2 "SMSBP" = Standardized Medicare Supplement Benefit Plan - Use "P" for prestandardized plans.
3 Year 1 is the current calendar year − 1. Year 2 is the current calendar year − 2 (etc.). (Example: If the current year is 1991, then: Year 1 is 1990; Year 2 is 1989, etc.)
4 For the calendar year on the appropriate line in column (a), the premium earned during that year for policies issued in that year.
5 These loss ratios are not explicitly used in computing the benchmark loss ratios. They are the loss ratios, on a policy year basis, which result in the cumulative loss ratios displayed on this worksheet. They are shown here for informational purposes only.
6 To include the earned premium for all years prior to as well as the 15th year prior to the current year.

REPORTING FORM FOR THE CALCULATION OF
BENCHMARK RATIO SINCE INCEPTION FOR INDIVIDUAL POLICIES
FOR CALENDAR YEAR _____

TYPE[1] _____ SMSBP[2] _____
For the State of _____ Company Name _____
NAIC Group Code _____ NAIC Company Code _____
Address _____ Person Completing Exhibit _____
Title _____ Telephone Number _____

(a)[3]	(b)[4]	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(o)[5]
Year	Earned Premium	Factor	(b)×(c)	Cumulative Loss Ratio	(d)×(e)	Factor	(b)×(g)	Cumulative Loss Ratio	(h)×(i)	Policy Year Loss Ratio
1		2.770		0.442		0.000		0.000		0.40
2		4.175		0.493		0.000		0.000		0.55
3		4.175		0.493		1.194		0.659		0.65
4		4.175		0.493		2.245		0.669		0.67
5		4.175		0.493		3.170		0.678		0.69
6		4.175		0.493		3.998		0.686		0.71
7		4.175		0.493		4.754		0.695		0.73
8		4.175		0.493		5.445		0.702		0.75
9		4.175		0.493		6.075		0.708		0.76
10		4.175		0.493		6.650		0.713		0.76
11		4.175		0.493		7.176		0.717		0.76
12		4.175		0.493		7.655		0.720		0.77
13		4.175		0.493		8.093		0.723		0.77
14		4.175		0.493		8.493		0.725		0.77
15+[6]		4.175		0.493		8.684		0.725		0.77
Total:			(k):		(l):		(m):		(n):	

Benchmark Ratio Since Inception: (l + n)/(k + m): _____

1 Individual, Group, Individual Medicare Select, or Group Medicare Select only.
2 "SMSBP" = Standardized Medicare Supplement Benefit Plan - Use "P" for prestandardized plans.
3 Year 1 is the current calendar year − 1. Year 2 is the current calendar year − 2 (etc.). (Example: If the current year is 1991, then: Year 1 is 1990; Year 2 is 1989, etc.)
4 For the calendar year on the appropriate line in column (a), the premium earned during that year for policies issued in that year.
5 These loss ratios are not explicitly used in computing the benchmark loss ratios. They are the loss ratios, on a policy year basis, which result in the cumulative loss ratios displayed on this worksheet. They are shown here for informational purposes only.
6 To include the earned premium for all years prior to as well as the 15th year prior to the current year.

INSURANCE DIVISION[191](cont'd)

ITEM 22. Rescind **191—Chapter 37**, **Appendix C**, and adopt the following **new** appendix in lieu thereof:

APPENDIX C

DISCLOSURE STATEMENTS
Instructions for Use of the Disclosure Statements for Health Insurance Policies
Sold to Medicare Beneficiaries that Duplicate Medicare

1. Section 1882(d) of the federal Social Security Act [42 U.S.C. 1395ss] prohibits the sale of a health insurance policy (the term policy includes certificate) to Medicare beneficiaries that duplicates Medicare benefits unless it will pay benefits without regard to a beneficiary's other health coverage and it includes the prescribed disclosure statement on or together with the application for the policy.

2. All types of health insurance policies that duplicate Medicare shall include one of the attached disclosure statements, according to the particular policy type involved, on the application or together with the application. The disclosure statement may not vary from the attached statements in terms of language or format (type size, type proportional spacing, bold character, line spacing, and usage of boxes around text).

3. State and federal law prohibits insurers from selling a Medicare supplement policy to a person that already has a Medicare supplement policy except as a replacement policy.

4. Property/casualty and life insurance policies are not considered health insurance.

5. Disability income policies are not considered to provide benefits that duplicate Medicare.

6. Long-term care insurance policies that coordinate with Medicare and other health insurance are not considered to provide benefits that duplicate Medicare.

7. The federal law does not preempt state laws that are more stringent than the federal requirements.

8. The federal law does not preempt existing state form filing requirements.

9. Section 1882 of the federal Social Security Act was amended in Subsection (d)(3)(A) to allow for alternative disclosure statements. The disclosure statements already in Appendix C remain. Carriers may use either disclosure statement with the requisite insurance product. However, carriers should use either the original disclosure statements or the alternative disclosure statements and not use both simultaneously.

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INSURANCE DIVISION[191](cont'd)

[Original disclosure statement for policies that provide benefits for expenses incurred for an accidental injury only.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses that result from accidental injury. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when it pays:
- Hospital or medical expenses up to the maximum stated in the policy

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:
- Hospitalization
- Physician services
- [Outpatient Prescription Drugs if you are enrolled in Medicare Part D]
- Other approved items and services

Before You Buy This Insurance

√ Check the coverage in all health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIP).

Drafting Note: Insurers insert reference to: Outpatient Prescription Drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.

***

[Original disclosure statement for policies that provide benefits for specified limited services.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for expenses relating to the specific services listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when:
- Any of the services covered by the policy are also covered by Medicare

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:
- Hospitalization
- Physician services
- [Outpatient Prescription Drugs if you are enrolled in Medicare Part D]
- Other approved items and services

Before You Buy This Insurance

√ Check the coverage in all health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIP).

Drafting Note: Insurers insert reference to: Outpatient Prescription Drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.

INSURANCE DIVISION[191](cont'd)

[Original disclosure statement for policies that reimburse expenses incurred for specified diseases or other specified impairments. This includes expense-incurred cancer, specified disease and other types of health insurance policies that limit reimbursement to named medical conditions.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses only when you are treated for one of the specific diseases or health conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when it pays:
- Hospital or medical expenses up to the maximum stated in the policy

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:
- Hospitalization
- Physician services
- Hospice
- [Outpatient Prescription Drugs if you are enrolled in Medicare Part D]
- Other approved items and services

Before You Buy This Insurance

√ Check the coverage in all health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIP).

Drafting Note: Insurers insert reference to: Outpatient Prescription Drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.

***

[Original disclosure statement for policies that pay fixed dollar amounts for specified diseases or other specified impairments. This includes cancer, specified disease, and other health insurance policies that pay a scheduled benefit or specific payment based on diagnosis of the conditions named in the policy.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for one of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits because Medicare generally pays for most of the expenses for the diagnosis and treatment of the specific conditions or diagnoses named in the policy.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:
- Hospitalization
- Physician services
- Hospice
- [Outpatient Prescription Drugs if you are enrolled in Medicare Part D]
- Other approved items and services

Before You Buy This Insurance

√ Check the coverage in all health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIP).

Drafting Note: Insurers insert reference to: Outpatient Prescription Drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.

INSURANCE DIVISION[191](cont'd)

[Original disclosure statement for indemnity policies and other policies that pay a fixed dollar amount per day, excluding long-term care policies.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance pays a fixed dollar amount, regardless of your expenses, for each day you meet the policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when:
- Any expenses or services covered by the policy are also covered by Medicare

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:
- Hospitalization
- Physician services
- [Outpatient Prescription Drugs if you are enrolled in Medicare Part D]
- Hospice
- Other approved items and services

Before You Buy This Insurance

√ Check the coverage in all health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIP).

Drafting Note: Insurers insert reference to: Outpatient Prescription Drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.

***

[Original disclosure statement for policies that provide benefits upon both an expense-incurred and fixed indemnity basis.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance pays limited reimbursement for expenses if you meet the conditions listed in the policy. It also pays a fixed amount, regardless of your expenses, if you meet other policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when:
- Any expenses or services covered by the policy are also covered by Medicare; or
- It pays the fixed dollar amount stated in the policy and Medicare covers the same event

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:
- Hospitalization
- Physician services
- Hospice care
- [Outpatient Prescription Drugs if you are enrolled in Medicare Part D]
- Other approved items and services

Before You Buy This Insurance

√ Check the coverage in all health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIP).

Drafting Note: Insurers insert reference to: Outpatient Prescription Drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.

INSURANCE DIVISION[191](cont'd)

[Original disclosure statement for other health insurance policies not specifically identified in the preceding statements.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance provides limited benefits if you meet the conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when it pays:
- The benefits stated in the policy and coverage for the same event is provided by Medicare

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:
- Hospitalization
- Physician services
- Hospice
- [Outpatient Prescription Drugs if you are enrolled in Medicare Part D]
- Other approved items and services

Before You Buy This Insurance

√ Check the coverage in all health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIP).

Drafting Note: Insurers insert reference to: Outpatient Prescription Drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.

***

[Alternative disclosure statement for policies that provide benefits for expenses incurred for an accidental injury only.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses that result from accidental injury. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:
- Hospitalization
- Physician services
- [Outpatient Prescription Drugs if you are enrolled in Medicare Part D]
- Other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in all health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIP).

Drafting Note: Insurers insert reference to: Outpatient Prescription Drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.

INSURANCE DIVISION[191](cont'd)

[Alternative disclosure statement for policies that provide benefits for specified limited services.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits under this policy.

This insurance provides limited benefits, if you meet the policy conditions, for expenses relating to the specific services listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:
- Hospitalization
- Physician services
- [Outpatient Prescription Drugs if you are enrolled in Medicare Part D]
- Other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in all health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIP).

Drafting Note: Insurers insert reference to: Outpatient Prescription Drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.

***

[Alternative disclosure statement for policies that reimburse expenses incurred for specified diseases or other specified impairments. This includes expense-incurred cancer, specified disease and other types of health insurance policies that limit reimbursement to named medical conditions.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy. Medicare generally pays for most or all of these expenses.

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses only when you are treated for one of the specific diseases or health conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:
- Hospitalization
- Physician services
- Hospice
- [Outpatient Prescription Drugs if you are enrolled in Medicare Part D]
- Other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in all health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIP).

Drafting Note: Insurers insert reference to: Outpatient Prescription Drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.

INSURANCE DIVISION[191](cont'd)

[Alternative disclosure statement for policies that pay fixed dollar amounts for specified diseases or other specified impairments. This includes cancer, specified disease, and other health insurance policies that pay a scheduled benefit or specific payment based on diagnosis of the conditions named in the policy.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for one of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:
- Hospitalization
- Physician services
- Hospice
- [Outpatient Prescription Drugs if you are enrolled in Medicare Part D]
- Other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in all health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIP).

Drafting Note: Insurers insert reference to: Outpatient Prescription Drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.

***

[Alternative disclosure statement for indemnity policies and other policies that pay a fixed dollar amount per day, excluding long-term care policies.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance pays a fixed dollar amount, regardless of your expenses, for each day you meet the policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:
- Hospitalization
- Physician services
- Hospice
- [Outpatient Prescription Drugs if you are enrolled in Medicare Part D]
- Other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in all health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIP).

Drafting Note: Insurers insert reference to: Outpatient Prescription Drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.

INSURANCE DIVISION[191](cont'd)

[Alternative disclosure statement for policies that provide benefits upon both an expense-incurred and fixed indemnity basis.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICAL SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance pays limited reimbursement for expenses if you meet the conditions listed in the policy. It also pays a fixed amount, regardless of your expenses, if you meet other policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:
- Hospitalization
- Physician services
- Hospice care
- [Outpatient Prescription Drugs if you are enrolled in Medicare Part D]
- Other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in all health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIP).

Drafting Note: Insurers insert reference to: Outpatient Prescription Drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.

***

[Alternative disclosure statement for other health insurance policies not specifically identified in the preceding statements.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance provides limited benefits if you meet the conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:
- Hospitalization
- Physician services
- Hospice
- [Outpatient Prescription Drugs if you are enrolled in Medicare Part D]
- Other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in all health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or your state health insurance assistance program (SHIP).

Drafting Note: Insurers insert reference to: Outpatient Prescription Drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.

ARC 3754B

REVENUE DEPARTMENT[701]

Notice of Intended Action

Twenty-five interested persons, a governmental subdivision, an agency or association of 25 or more persons may demand an oral presentation hereon as provided in Iowa Code section 17A.4(1)"*b*."

Notice is also given to the public that the Administrative Rules Review Committee may, on its own motion or on written request by any individual or group, review this proposed action under section 17A.8(6) at a regular or special meeting where the public or interested persons may be heard.

Pursuant to the authority of Iowa Code sections 421.14 and 422.68, the Department of Revenue hereby gives Notice of Intended Action to amend Chapter 42, "Adjustments to Computed Tax," and Chapter 52, "Filing Returns, Payment of Tax and Penalty and Interest," Iowa Administrative Code.

These amendments are proposed as a result of the Iowa Supreme Court decision in Rants v. Vilsack, 684 N.W. 2d 193 (Iowa 2004), which invalidated the enactment of provisions contained in 2003 Iowa Acts, First Extraordinary Session, House File 692.

Item 1 amends subrule 42.15(2) to eliminate, for individual income tax, the provision that for fiscal years beginning July 1, 2005, and July 1, 2006, an additional $500,000 of property rehabilitation tax credits are appropriated for projects located in cultural and entertainment districts certified by the Department of Cultural Affairs.

Item 2 rescinds and reserves rule 701—42.21(422) to eliminate, for individual income tax, the university-based research utilization program tax credit available to eligible businesses approved by the Iowa Department of Economic Development and to eligible employees of educational institutions who develop technologies for eligible businesses.

Item 3 amends subrule 52.18(2) to eliminate, for corporation income tax, the provision that for fiscal years beginning July 1, 2005, and July 1, 2006, an additional $500,000 of property rehabilitation tax credits are appropriated for projects located in cultural and entertainment districts certified by the Department of Cultural Affairs. This amendment is similar to the amendment in Item 1.

Item 4 rescinds and reserves rule 701—52.24(422) to eliminate, for corporation income tax, the university-based research utilization program tax credit available to eligible businesses approved by the Iowa Department of Economic Development and to eligible employees of educational institutions who develop technologies for eligible businesses. This amendment is similar to the amendment in Item 2.

The proposed amendments will not necessitate additional expenditures by political subdivisions or agencies and entities which contract with political subdivisions.

Any person who believes that the application of the discretionary provisions of these amendments would result in hardship or injustice to that person may petition the Department for a waiver of the discretionary provisions, if any.

The Department has determined that these proposed amendments may have an impact on small business. The Department has considered the factors listed in Iowa Code section 17A.4A. The Department will issue a regulatory analysis as provided in Iowa Code section 17A.4A if a written request is filed by delivery or by mailing postmarked no later than November 29, 2004, to the Policy Section, Compliance Division, Department of Revenue, Hoover State Office Building, P.O. Box 10457, Des Moines, Iowa 50306. The request may be made by the Administrative Rules Review Committee, the Administrative Rules Coordinator, at least 25 persons signing that request who each qualify as a small business or an organization representing at least 25 such persons.

Any interested person may make written suggestions or comments on these proposed amendments on or before November 16, 2004. Such written comments should be directed to the Policy Section, Compliance Division, Department of Revenue, Hoover State Office Building, P.O. Box 10457, Des Moines, Iowa 50306.

Persons who want to convey their views orally should contact the Policy Section, Compliance Division, Department of Revenue, at (515)281-8036 or at the Department of Revenue offices on the fourth floor of the Hoover State Office Building.

Requests for a public hearing must be received by November 19, 2004.

These amendments are intended to implement the Iowa Supreme Court decision in Rants v. Vilsack, 684 N.W. 2d 193 (Iowa 2004), which invalidated the enactment of provisions contained in 2003 Iowa Acts, First Extraordinary Session, House File 692, sections 110 through 113.

A fiscal impact summary prepared by the Legislative Services Agency pursuant to Iowa Code Supplement § 17A.4(3) will be available at http://www.legis.state.ia.us/IAC.html or at (515)281-5279 prior to the Administrative Rules Review Committee's review of this rule making.

The following amendments are proposed.

ITEM 1. Amend subrule 42.15(2), introductory paragraph, as follows:

42.15(2) Application and review process for the property rehabilitation credit. Taxpayers who want to claim an income tax credit for completing a property rehabilitation project must submit an application for approval of the project. The application forms for the property rehabilitation credit may be requested from the State Tax Credit Program Manager, State Historic Preservation Office, Department of Cultural Affairs, 600 E. Locust, Des Moines, Iowa 50319-0290. The telephone number for this office is (515)281-4137. Applications for the credit will be accepted by the state historic preservation office on or after July 1, 2000, until such time as all the available credits allocated for each fiscal year are encumbered. For fiscal years beginning on or after July 1, 2000, $2.4 million shall be appropriated for property rehabilitation tax credits for each year. ~~For the fiscal years beginning July 1, 2005, and July 1, 2006, an additional $500,000 of property rehabilitation tax credits is appropriated for projects located in cultural and entertainment districts which are certified by the department of cultural affairs. If less than $500,000 of tax credits is appropriated during the fiscal year beginning July 1, 2005, the remaining amount may be carried over to the fiscal year beginning July 1, 2006.~~

ITEM 2. Rescind and reserve rule **701—42.21(422)**.

ITEM 3. Amend subrule 52.18(2), introductory paragraph, as follows:

52.18(2) Application and review process for the property rehabilitation credit. Taxpayers who want to claim an income tax credit for completing a property rehabilitation project must submit an application for approval of the project. The application forms for the property rehabilitation credit may be requested from the State Tax Credit Program Manager, State Historic Preservation Office, Department of Cultural Affairs, 600 E. Locust, Des Moines, Iowa 50319-0290. The telephone number for this office is (515)281-4137. Applications for the credit will be accepted by the state historic preservation office on or after July 1, 2000, until such time as

REVENUE DEPARTMENT[701](cont'd)

all the available credits allocated for each fiscal year are encumbered. For fiscal years beginning on or after July 1, 2000, $2.4 million shall be appropriated for property rehabilitation tax credits for each year. ~~For the fiscal years beginning July 1, 2005, and July 1, 2006, an additional $500,000 of property rehabilitation tax credits is appropriated for projects located in cultural and entertainment districts which are certified by the department of cultural affairs. If less than $500,000 of tax credits is appropriated during the fiscal year beginning July 1, 2005, the remaining amount may be carried over to the fiscal year beginning July 1, 2006.~~

ITEM 4. Rescind and reserve rule **701—52.24(422)**.

NOTICE—PUBLIC FUNDS INTEREST RATES

In compliance with Iowa Code chapter 74A and section 12C.6, the committee composed of Treasurer of State Michael L. Fitzgerald, Superintendent of Credit Unions James E. Forney, Superintendent of Banking Thomas B. Gronstal, and Auditor of State David A. Vaudt have established today the following rates of interest for public obligations and special assessments. The usury rate for October is 6.25%.

INTEREST RATES FOR PUBLIC OBLIGATIONS AND ASSESSMENTS

74A.2 Unpaid Warrants . . . . . Maximum 6.0%
74A.4 Special Assessments . . . . . Maximum 9.0%

RECOMMENDED Rates for Public Obligations (74A.3) and School District Warrants (74A.7). A rate equal to 75% of the Federal Reserve monthly published indices for U.S. Government securities of comparable maturities. All Iowa Banks and Iowa Savings Associations as defined by Iowa Code section 12C.1 are eligible for public fund deposits as defined by Iowa Code section 12C.6A.

The rate of interest has been determined by a committee of the state of Iowa to be the minimum interest rate that shall be paid on public funds deposited in approved financial institutions. To be eligible to accept deposits of public funds of the state of Iowa, a financial institution shall demonstrate a commitment to serve the needs of the local community in which it is chartered to do business. These needs include credit services as well as deposit services. All such financial institutions are required to provide the committee with a written description of their commitment to provide credit services in the community. This statement is available for examination by citizens.

New official state interest rates, effective October 13, 2004, setting the minimums that may be paid by Iowa depositories on public funds are listed below.

TIME DEPOSITS

7-31 days . . . . . Minimum 0.85%
32-89 days . . . . . Minimum 0.95%
90-179 days . . . . . Minimum 1.05%
180-364 days . . . . . Minimum 1.38%
One year to 397 days . . . . . Minimum 1.55%
More than 397 days . . . . . Minimum 2.65%

These are minimum rates only. The one year and less are four-tenths of a percent below average rates. Public body treasurers and their depositories may negotiate a higher rate according to money market rates and conditions.

Inquiries may be sent to Michael L. Fitzgerald, Treasurer of State, State Capitol, Des Moines, Iowa 50319.

ARC 3751B

ADMINISTRATIVE SERVICES DEPARTMENT[11]

Adopted and Filed Emergency

Pursuant to the authority of 2003 Iowa Code Supplement section 8A.104, the Department of Administrative Services hereby amends Chapter 10, "Customer Councils," Iowa Administrative Code.

The purpose of these amendments is to improve continuity of customer council operations by extending the length of a member's term from two years to three years and changing the initial staggering of terms so that roughly one-third of the membership of each council is replaced annually. Experience gained during the first year of utilizing customer councils has shown that the complexity of the rate-setting process and the other responsibilities assigned to the customer councils require a certain level of expertise on relevant issues that takes some time to develop. A council's knowledge base could be adversely affected if it lost a majority of its members at one time. In addition, the longer terms would allow at least a portion of the council members to remain in office during the time the rates they have set are in effect.

This realignment will result in new initial terms of:

- Two years for a representative of a small, a medium-sized, and a large agency on each council and the public member;
- Three years for a representative of a small, a medium-sized, and a large agency on each council and any optional members (judicial, legislative, and ex-officio members); and
- Four years for a representative of a small, a medium-sized, and a large agency on each council and the union member.

Implementation of the amendments will be accomplished as follows:

- All two-year terms will be converted to three-year terms, and all one-year terms to two-year terms, except
  - The public member will retain a two-year term; and
  - The union member's three-year term will be converted to a four-year term.

Members on the council from each agency size group will select:

- One representative of the small agencies to have that representative's two-year term converted to a four-year term; and
- One representative of the medium-sized agencies and one representative of the large agencies to have their three-year terms converted to four-year terms.

If the bylaws are in conflict, the councils will revise their bylaws to reflect the amended rule.

In compliance with Iowa Code section 17A.4(2), the Department finds that notice and public participation are impracticable because of the immediate need for the rule change to continue the initial one-year terms.

The Department also finds, pursuant to Iowa Code section 17A.5(2)"b"(2), that the normal effective date of the amendments should be waived and these amendments should be made effective on October 11, 2004, as the amendments confer the benefit of improving the performance and continuity of DAS customer councils.

The Department of Administrative Services adopted these amendments October 7, 2004.

These amendments became effective October 11, 2004.

These amendments are intended to implement 2003 Iowa Code Supplement section 8A.121.

A fiscal impact summary prepared by the Legislative Services Agency pursuant to Iowa Code Supplement § 17A.4(3) will be available at http://www.legis.state.ia.us/IAC.html or at (515)281-5279 prior to the Administrative Rules Review Committee's review of this rule making.

The following amendments are adopted.

ITEM 1. Amend **11—Chapter 10** by replacing all parenthetical references to "80GA,HF534" with references to "8A."

ITEM 2. Amend rule **11—10.1(8A)**, definition of "department," as follows:

"Department" means the department of administrative services (DAS) created by 2003 Iowa ~~Acts,~~ *Code Supplement* ~~House File 534,~~ section ~~2~~ *8A.102*.

ITEM 3. Amend subrule 10.5(3) as follows:

10.5(3) Term of membership. Each member will serve a ~~two~~ *three*-year term; however, to ensure continuity of council functions, the first term for one representative of ~~a~~ *the* large ~~agency~~ *agencies*, one representative of ~~a~~ *the* medium-sized ~~agency~~ *agencies*, ~~and two~~ *one* ~~representatives~~ *representative* of *the* small agencies, *and for the public member* will be a ~~12-month~~ *two-year* term*; and one member from each agency size group and the union member will start with a four-year term*. The agencies filling the initial ~~12-month~~ *two-year and four-year* terms shall be selected by a vote of the members from agencies in each respective size group. Initial membership terms shall begin on July 1, 2003.

ITEM 4. Amend **11—Chapter 10**, implementation clause, as follows:

These rules are intended to implement 2003 Iowa ~~Acts,~~ *Code Supplement* ~~House File 534,~~ section ~~11~~ *8A.121*.

[Filed Emergency 10/7/04, effective 10/11/04]
[Published 10/27/04]

EDITOR'S NOTE: For replacement pages for IAC, see IAC Supplement 10/27/04.

ARC 3759B

HUMAN SERVICES DEPARTMENT[441]

Adopted and Filed

Pursuant to the authority of Iowa Code section 249A.4, the Department of Human Services amends Chapter 75, "Conditions of Eligibility," Iowa Administrative Code.

The amendments fulfill the statutory requirements for the Department to publish annual updates of:

- The statewide average cost of nursing facility services to a private-pay resident, used in determining Medicaid eligibility for a person who has transferred assets for less than fair market value.
- The statewide average charges or maximum Medicaid rate for various levels of institutional care, used in determining the disposition of income from a medical assistance income trust. 2004 Iowa Acts, House File 2378, amended the categories for which amounts are published.

These amendments were previously Adopted and Filed Emergency and were published in the Iowa Administrative Bulletin on July 7, 2004, as **ARC 3465B**. Notice of Intended Action on these amendments was published in the Iowa Administrative Bulletin as **ARC 3455B** on the same date to solicit comment. The Department received no comments on these amendments. These amendments are identical to those published under Notice of Intended Action.

These amendments do not provide for waivers in specified situations because everyone should be subject to the same conditions in determining Medicaid eligibility as a matter of fairness, and these changes provide a benefit to applicants and recipients.

The Council on Human Services adopted these amendments September 15, 2004.

These amendments are intended to implement Iowa Code section 249A.4 and sections 633.707 and 633.709 as amended by 2004 Iowa Acts, House File 2378.

These amendments will become effective December 1, 2004, at which time the Adopted and Filed Emergency amendments are rescinded.

The following amendments are adopted.

ITEM 1. Amend subrule 75.23(3) as follows:

75.23(3) Period of ineligibility. The number of months of ineligibility shall be equal to the total cumulative uncompensated value of all assets transferred by the individual (or the individual's spouse) on or after the look-back date specified in 75.23(2), divided by the statewide average private-pay rate for nursing facility services at the time of application. The department shall determine the average statewide cost to a private-pay resident for nursing facilities and update the cost annually. For the period from July 1, ~~2003~~ *2004*, through June 30, ~~2004~~ *2005*, this average statewide cost shall be ~~$3,575.34~~ *$3,597.84* per month or ~~$117.61~~ *$118.35* per day.

ITEM 2. Amend paragraph **75.24(3)"b"** as follows:

Amend the first unnumbered paragraph and subparagraph **(1)** as follows:

For disposition of trust amounts pursuant to Iowa Code sections 633.707 to 633.711, the average statewide charges and Medicaid rates for the period from July 1, ~~2003~~ *2004*, to June 30, ~~2004~~ *2005*, shall be as follows:

(1) The average statewide charge to a private-pay resident of a nursing facility is ~~$3,180~~ *$3,246* per month.

Rescind and reserve subparagraphs **(2)** and **(3)**.

Amend subparagraphs **(4)** and **(5)** as follows:

(4) The maximum statewide Medicaid rate for a resident of an intermediate care facility for the mentally retarded is ~~$10,734~~ *$10,752* per month.

(5) The average statewide charge to a resident of a mental health institute is ~~$9,991~~ *$13,299* per month.

[Filed 10/8/04, effective 12/1/04]
[Published 10/27/04]

EDITOR'S NOTE: For replacement pages for IAC, see IAC Supplement 10/27/04.

ARC 3757B

IOWA FINANCE AUTHORITY[265]

Adopted and Filed

Pursuant to the authority of Iowa Code sections 17A.3(1)"b," 16.5(17) and 16.18(1), the Iowa Finance Authority hereby amends Chapter 3, "Multifamily Housing," Iowa Administrative Code.

These amendments expand the types of loans available under Chapter 3, expand the range of eligible borrowers and add a new division for gap financing loans. Division I of Chapter 3 is changed from a loan preservation program to a program for both preservation of existing units and construction of new affordable developments. The amendments to Division I include general guidelines for multifamily loans and specific requirements applicable to the three categories of loans to be made under this division: (1) loans for preservation of affordable housing; (2) loans for tax credit developments; and (3) loans for substantial rehabilitation of developments not currently restricted for use as affordable housing.

The changes to Division II of Chapter 3, the predevelopment loan fund, expand the range of eligible borrowers to include for-profit organizations and make this loan fund available for a broader range of multifamily loans.

Finally, the amendments add to this chapter a new Division III for a gap financing fund. The rules outline the application procedure, loan fund guidelines, and other necessary requirements of the gap financing fund.

These rules do not contain a waiver provision, as the Authority does not intend to grant waivers under this program, other than as may be allowed pursuant to Chapter 18 of the Authority's rules.

Notice of Intended Action was published in the September 1, 2004, Iowa Administrative Bulletin as **ARC 3620B**. No public comment was received on these amendments. The adopted amendments are identical to those published under Notice of Intended Action.

The Authority adopted these amendments on October 6, 2004.

These amendments will become effective on December 1, 2004.

These amendments are intended to implement Iowa Code sections 16.5(17) and 16.18(1).

EDITOR'S NOTE: Pursuant to recommendation of the Administrative Rules Review Committee published in the Iowa Administrative Bulletin, September 10, 1986, the text of these amendments [amendments to Ch 3] is being omitted.

IOWA FINANCE AUTHORITY[265](cont'd)

These amendments are identical to those published under Notice as **ARC 3620B**, IAB 9/1/04.

[Filed 10/8/04, effective 12/1/04]
[Published 10/27/04]

[For replacement pages for IAC, see IAC Supplement 10/27/04.]

ARC 3758B

IOWA FINANCE AUTHORITY[265]

Adopted and Filed

Pursuant to the authority of Iowa Code sections 17A.3(1)"b" and 16.5(17) and Iowa Code Supplement section 16.181, the Iowa Finance Authority amends Chapter 19, "State Housing Trust Fund," Iowa Administrative Code.

This amendment replaces the current allocation plan for the State Housing Trust Fund with the 2005 allocation plan, which is incorporated by reference in rule 19.1(16).

The allocation plan sets forth the purpose of the State Housing Trust Fund, the administrative information required for participation in the program, the threshold criteria, the selection criteria and other applicable requirements. Copies of the trust fund allocation plan are available upon request from the Authority and are available electronically on the Authority's Web site at www.ifahome.com. It is the Authority's intent to incorporate the 2005 trust fund allocation plan by reference consistent with Iowa Code chapter 17A and 265—subrules 17.4(2) and 17.12(2).

These rules do not contain a waiver provision, as the Authority does not intend to grant waivers under this program, other than as may be allowed pursuant to Chapter 18 of the Authority's rules.

Notice of Intended Action was published in the August 4, 2004, Iowa Administrative Bulletin as **ARC 3558B**. The Authority held a public hearing over the Iowa Communications Network on August 24, 2004, to receive public comments on the 2005 trust fund allocation plan. The Authority received written comments in addition to the oral comments received at the public hearing. No changes to the actual text of the amendment to the rule have been made, as the changes were made to the allocation plan incorporated by reference.

The Authority received both oral and written public comments on the draft allocation plan. These public comments addressed the proposed preference of awarding funds to newly formed local housing trust funds over existing local housing trust funds.

The Authority revised the draft allocation plan based on the public comments received. One revision allows for a second round of funding for existing trust funds if funds remain after awards are made to newly formed local housing trust funds. A second revision removes the $125,000 sales price requirement for single-family construction projects.

The Authority adopted this amendment on October 6, 2004.

This amendment will become effective on December 1, 2004.

This amendment is intended to implement Iowa Code section 16.5(17) and Iowa Code Supplement section 16.181.

The following amendment is adopted.

Amend rule 265—19.1(16) as follows:

265—19.1(16) Trust fund allocation plan. The trust fund allocation plan entitled Iowa Finance Authority State Housing Trust Fund ~~2004~~ *2005* Allocation Plan, effective ~~December 31, 2003~~ *December 1, 2004*, shall be the allocation plan for the distribution of funds held within the state housing trust fund established in ~~2003 Iowa Acts, Senate File 458, section 101~~ *Iowa Code Supplement section 16.181*. The trust fund allocation plan includes the plan, application and application instructions. The trust fund allocation plan is incorporated by reference pursuant to Iowa Code section 17A.6 and 265—subrules 17.4(2) and 17.12(2).

[Filed 10/8/04, effective 12/1/04]
[Published 10/27/04]

EDITOR'S NOTE: For replacement pages for IAC, see IAC Supplement 10/27/04.

ARC 3747B

NURSING BOARD[655]

Adopted and Filed

Pursuant to the authority of Iowa Code sections 17A.3 and 147.76, the Board of Nursing hereby adopts amendments to Chapter 3, "Licensure to Practice—Registered Nurse/Licensed Practical Nurse," Chapter 4, "Discipline," and Chapter 5, "Continuing Education," Iowa Administrative Code.

These amendments simplify reactivation processes, eliminate delinquent license status and place on inactive status all licenses not renewed within 30 days following the renewal date. One fee is established for reactivation to replace four different fees. Editorial changes in discipline and continuing education rules reflect changes in the reactivation process and create uniformity in the rules.

These amendments were published under Notice of Intended Action in the Iowa Administrative Bulletin on July 7, 2004, as **ARC 3470B**. No substantive changes have been made to the amendments published under Notice.

These amendments will become effective January 3, 2005.

These amendments are intended to implement Iowa Code chapters 17A, 147, 152, and 272C.

The following amendments are adopted.

ITEM 1. Amend rule **655—3.1(17A,147,152,272C)** by rescinding the definitions of "delinquent licensee" and "lapsed license."

ITEM 2. Amend rule **655—3.1(17A,147,152,272C)** by amending the definition of "fees," numbered paragraph **"7,"** to read as follows:

7. For reactivation of a license to practice as a registered nurse/licensed practical nurse, ~~based on $33 per year, or any portion of a year,~~ ~~$99~~ *175* for a license lasting more than 24 months up to 36 months.

ITEM 3. Amend rule **655—3.1(17A,147,152,272C)**, definition of "fees," by rescinding numbered paragraph **"11"** and renumbering **"12"** to **"15"** as **"11"** to **"14."**

ITEM 4. Amend rule **655—3.1(17A,147,152,272C)** by rescinding the definition of "inactive licensee" and inserting in lieu thereof the following **new** definition:

"Inactive license" means a registered nurse or licensed practical nurse license that has been placed on inactive status because it was not renewed by the fifteenth day of the month

following the expiration date, or the board has received notification that a licensee has declared another compact state as primary state of residency. Pursuant to 655—subrule 16.2(4), the former home state license shall no longer be valid upon the issuance of a new home state license.

ITEM 5. Amend rule **655—3.1(17A,147,152,272C)** by rescinding the definition of "late licensee" and inserting in lieu thereof the following **new** definition:

"Late license" means a registered nurse or licensed practical nurse license that has not been renewed by the expiration date on the wallet card. The time between the expiration date and the fifteenth day of the month following the expiration date is considered a grace period.

ITEM 6. Amend rule **655—3.1(17A,147,152,272C)**, definition of "reinstatement," to read as follows:

"Reinstatement" means the process by which ~~a delinquent licensee obtains a current license~~ *any person whose license to practice nursing has been suspended, revoked or voluntarily surrendered by order of the board may apply for license consideration*.

ITEM 7. Amend rule **655—3.1(17A,147,152,272C)**, definition of "verification," to read as follows:

"Verification" means the process whereby the board provides a certified statement that the license of a registered nurse/licensed practical nurse is active, inactive, or ~~lapsed~~ *encumbered*, or an advanced registered nurse practitioner is registered in this state.

ITEM 8. Rescind subrule 3.7(4) and insert in lieu thereof the following **new** subrule:

3.7(4) Late renewal. The license shall become late when the license has not been renewed by the expiration date on the wallet card. The licensee shall be assessed a late fee as specified in rule 3.1(17A,147,152,272C).

To renew a late license, the licensee shall complete the renewal requirements and submit the late fee before the fifteenth day of the month following the expiration date on the wallet card.

ITEM 9. Rescind subrule 3.7(5) and insert in lieu thereof the following **new** subrule:

3.7(5) Inactive status. The license shall become inactive when the license has not been renewed by the fifteenth day of the month following the expiration date on the wallet card or the board office has been notified by another compact state that a licensee has declared a new primary state. Pursuant to 655—subrule 16.2(4), the former home state license shall no longer be valid upon the issuance of a new home state license.

a. If the inactive license is not reactivated, it shall remain inactive.

b. If the licensee resides in Iowa or a noncompact state, the licensee shall not practice nursing in Iowa until the license is reactivated to active status. If the licensee is identified as practicing nursing with an inactive license, disciplinary proceedings shall be initiated.

c. The licensee is not required to obtain continuing education credit or pay fees while the license is inactive.

d. To reactivate the license, the licensee shall contact the board office.

(1) The licensee shall be provided an application, a continuing education report form and statement of the fee. The reactivation fee is specified in rule 3.1(17A,147,152,272C).

(2) The licensee shall have obtained 12 contact hours of continuing education, as specified in 655—Chapter 5, within the 12 months prior to reactivation.

(3) Upon receipt of the completed application, required continuing education materials, the renewal fee and verification that the primary state of residence is Iowa or a noncompact state, the licensee shall be issued a license for a 24- to 36-month period. At the time of the next renewal, the license will be placed on a three-year renewal cycle. Expiration shall be on the fifteenth day of the birth month.

ITEM 10. Rescind subrule **3.7(6)** and renumber subrules **3.7(7)** and **3.7(8)** as **3.7(6)** and **3.7(7)**.

ITEM 11. Amend rule 655—3.8(17A,147,152,272C) to read as follows:

655—3.8(17A,147,152,272C) Verification. Upon written request from the licensee or another jurisdiction and payment of the verification fee as specified in rule 3.1(17A,147,152,272C), the board shall provide a certified statement to another jurisdiction or entity that the license of a registered nurse/licensed practical nurse is active, inactive or ~~lapsed~~ *encumbered* in Iowa.

ITEM 12. Amend rule **655—4.7(17A,147,152,272C)**, numbered paragraph **"4,"** to read as follows:

4. Civil penalty. A fine may be imposed in accordance with Iowa Code section 272C.3(2)"e." Assessment of a fine shall be specified in the order and may not exceed a maximum amount of $1,000. Fines may be incurred for:

- Practicing without an active license: $50 for each calendar month or part thereof, beginning on the date that a license enters ~~delinquent~~ *inactive* status.
- Obtaining a license by falsification of continuing education records: $50 for each contact hour falsified.
- Violating rule 4.6(17A,147,152,272C): an amount deemed appropriate.

ITEM 13. Amend subrule 5.2(2), introductory paragraph, to read as follows:

5.2(2) Requirements. To obtain a registered nurse or licensed practical nurse license for the next renewal period, the licensee shall ~~submit a completed report form which documents~~ *verify* the completion of continuing education requirements or exceptions to the requirements, as outlined in subrule 5.2(3).

ITEM 14. Rescind subrule **5.2(2)**, paragraph **"a,"** subparagraph **(4)**.

ITEM 15. Amend subrule **5.2(2)**, paragraph **"c,"** to read as follows:

c. Continuing education credits from a previous license period *including all make-up credit* shall not be used, nor shall credits be accumulated for use in a future licensure period.

ITEM 16. Rescind subrule 5.2(4) and insert in lieu thereof the following **new** subrule:

5.2(4) Failure to meet requirements or conditions for exceptions to requirements. The licensee who fails to meet the requirements or the conditions for exceptions has the following options:

a. If the requirements or the conditions for exceptions are met during the late renewal period, as defined in rule 655—3.1(17A,147,152,272C), the licensee may retain the license in an active status.

(1) To remain active, the licensee shall complete the continuing education requirements as specified in subrule 5.2(2) or 5.2(3) as well as other requirements specified in 655—subrule 3.7(4). The licensee shall be required to submit to an audit of continuing education following the late renewal.

The licensee shall automatically be reaudited when late credit has been accepted.

(2) Failure to renew within 30 days after expiration shall cause the license to be placed on inactive status.

b. An inactive license as defined in rule 655—3.1(17A, 147,152,272C) may be reactivated.

c. To reactivate a license, the licensee shall obtain 12 contact hours of continuing education within the 12 months prior to reactivation and complete the requirements specified in 655—subrule 3.7(5).

ITEM 17. Amend subrule **5.2(5)** by relettering paragraphs **"b"** to **"g"** as **"c"** to **"h"** and adding the following **new** paragraph **"b"**:

b. The licensee must submit verification of the requirement specified in 655—subrule 3.7(3).

ITEM 18. Amend subrule **5.2(5)**, relettered paragraph **"d,"** to read as follows:

d. If submitted materials are incomplete or unsatisfactory, the licensee shall be notified. The licensee shall be given the opportunity to submit make-up credit to cover the deficit found through the audit. The deadline for receipt of the documentation for this make-up credit is within 90 days of receipt of the board office notification. *The licensee shall be reaudited during the next renewal period when make-up credit has been accepted.*

[Filed 10/1/04, effective 1/3/05]
[Published 10/27/04]

EDITOR'S NOTE: For replacement pages for IAC, see IAC Supplement 10/27/04.

ARC 3748B

PETROLEUM UNDERGROUND STORAGE TANK FUND BOARD, IOWA COMPREHENSIVE[591]

Adopted and Filed

Pursuant to the authority of Iowa Code section 455G.4(3), the Iowa Comprehensive Petroleum Underground Storage Tank Fund Board hereby adopts Chapter 14, "Aboveground Petroleum Storage Tank Fund," Iowa Administrative Code.

Chapter 14 provides rules and procedures for the reimbursement of claims for the removal or upgrade of aboveground storage tank sites.

This chapter was published under Notice of Intended Action in the Iowa Administrative Bulletin on May 12, 2004, as **ARC 3362B** and was also Adopted and Filed Emergency as **ARC 3361B** on the same date. No public comment was received. This amendment is identical to that published under Notice.

This amendment was approved September 23, 2004.

This amendment will become effective December 1, 2004, at which time the Adopted and Filed Emergency amendment is hereby rescinded.

These rules are intended to implement 2004 Iowa Acts, House File 2401, section 4.

EDITOR'S NOTE: Pursuant to recommendation of the Administrative Rules Review Committee published in the Iowa Administrative Bulletin, September 10, 1986, the text of these rules [Ch 14] is being omitted. These rules are identical to those published under Notice as **ARC 3362B** and Adopted and Filed Emergency as **ARC 3361B**, IAB 5/12/04.

[Filed 10/5/04, effective 12/1/04]
[Published 10/27/04]

[For replacement pages for IAC, see IAC Supplement 10/27/04.]

ARC 3756B

PROFESSIONAL LICENSURE DIVISION[645]

Adopted and Filed

Pursuant to the authority of Iowa Code section 147.76, the Board of Respiratory Care Examiners hereby amends Chapter 261, "Licensure of Respiratory Care Practitioners," and Chapter 262, "Continuing Education for Respiratory Care Practitioners," Iowa Administrative Code.

These amendments change continuing education hour requirements from 30 to 24 hours per biennium.

Notice of Intended Action was published in the Iowa Administrative Bulletin on July 7, 2004, as **ARC 3475B**. A public hearing was held on July 28, 2004, from 10 to 11 a.m. in the Fifth Floor Board Conference Room, Lucas State Office Building. One public comment was received suggesting that the required number of continuing education hours should remain at 30.

The Board reviewed the comment received and believes the reduced number of continuing education hours is appropriate for the profession.

One change was made from the amendments published under Notice of Intended Action. An item was added in order to make a nonsubstantive, editorial change in paragraph 261.8(4)"b."

These amendments were adopted by the Board of Respiratory Care Examiners on October 8, 2004.

These amendments will become effective December 1, 2004.

These amendments are intended to implement Iowa Code chapters 21, 147, 152B and 272C.

The following amendments are adopted.

ITEM 1. Amend paragraph **261.8(4)"b"** as follows:

b. A licensee who, in the course of employment ~~responsibilities~~, examines, attends, counsels or treats adults in Iowa shall indicate on the renewal application completion of two hours of training in dependent adult abuse identification and reporting in the previous five years or condition(s) for waiver of this requirement as identified in paragraph "e."

ITEM 2. Amend subrule 261.9(4) as follows:

261.9(4) A new licensee who is on inactive status during the initial license renewal time period and reinstates before the first license expiration date will not be required to complete continuing education for that first license renewal time period only. ~~Thirty~~ *Twenty-four* hours of continuing education will be required for every renewal thereafter.

ITEM 3. Amend subrule **261.9(6)** by striking "30 hours" and inserting "24 hours" in lieu thereof wherever it appears.

ITEM 4. Amend subrule **261.10(6)** by striking "30 hours" and inserting "24 hours" in lieu thereof and by strik-

ing "60 hours" and inserting "48 hours" in lieu thereof wherever they appear.

ITEM 5. Amend subrule 262.2(1) as follows:

262.2(1) The biennial continuing education compliance period shall extend for a two-year period beginning on April 1 of each even-numbered year and ending on March 31 of the next even-numbered year. Each biennium, each person who is licensed to practice as a licensee in this state shall be required to complete a minimum of ~~30~~ *24* hours of continuing education approved by the board.

ITEM 6. Amend subrule 262.2(2) as follows:

262.2(2) Requirements of new licensees. Those persons licensed for the first time shall not be required to complete continuing education as a prerequisite for the first renewal of their licenses. Continuing education hours acquired anytime from the initial licensing until the second license renewal may be used. The new licensee will be required to complete a minimum of ~~30~~ *24* hours of continuing education per biennium for each subsequent license renewal.

ITEM 7. Amend rule **645—262.6(152B,272C)**, numbered paragraph **"6,"** first bulleted paragraph, as follows:

- Satisfactory completion of continuing education requirements during the period since the license lapsed. The total number of continuing education hours required for license reinstatement is computed by multiplying ~~30~~ *24* by the number of bienniums since the license lapsed to a maximum of two bienniums or ~~60~~ *48* hours of continuing education credit;

ITEM 8. Amend subrule **262.10(2)**, paragraph **"b,"** as follows:

b. Successful completion of ~~30~~ *24* hours of approved continuing education hours; or

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[Published 10/27/04]

EDITOR'S NOTE: For replacement pages for IAC, see IAC Supplement 10/27/04.

ARC 3749B

PUBLIC SAFETY DEPARTMENT[661]

Adopted and Filed

Pursuant to the authority of Iowa Code section 97A.5, the Board of Trustees of the Iowa Department of Public Safety Peace Officers' Retirement, Accident, and Disability System hereby rescinds 581—Chapter 24, "Peace Officers' Retirement, Accident, and Disability System," and adopts 661—Chapter 400, "Peace Officers' Retirement, Accident, and Disability System—Governance and Administration," Chapter 401, "Peace Officers' Retirement, Accident, and Disability System—Administrative Procedures," Chapter 402, "Peace Officers' Retirement, Accident, and Disability System—Eligibility, Benefits, and Payments," Chapter 403, "Peace Officers' Retirement, Accident, and Disability System—Line-of-Duty Death Benefit," and Chapter 404, "Peace Officers' Retirement, Accident, and Disability System—Temporary Incapacity," Iowa Administrative Code.

Two bills enacted during the 2003 regular session of the Iowa General Assembly made significant changes in Iowa Code chapter 97A, which establishes the Iowa Department of Public Safety Peace Officers' Retirement, Accident, and Disability System. 2003 Iowa Acts, chapter 145, sections 168 and 169, transferred responsibility for providing administrative support for the System from the former Iowa Department of Personnel to the Iowa Department of Public Safety. 2003 Iowa Acts, chapter 20, amended a provision of the statute concerning active members of the System who are temporarily incapacitated as a result of an injury or illness which occurs or is aggravated at a definite time or place while on duty. A review of the current rules in 581—Chapter 24 identified several omissions. These amendments move the System's rules from the Department of Personnel to the Department of Public Safety, deal with the subject of temporary incapacity, and address other omissions in the current rules, including benefits paid subsequent to a line-of-duty death, procedures for waivers of these rules, and appeal and contested case procedures.

These amendments were proposed in a Notice of Intended Action published in the Iowa Administrative Bulletin on August 18, 2004, as **ARC 3586B**. A public hearing on these proposed amendments was held on September 8, 2004. No comments were received from the public either at the public hearing or otherwise. However, extensive discussions regarding these rules were held with representatives of the members of the Public Safety Peace Officers' Retirement System prior to the publication of the proposed rules. The rules adopted here are identical to those proposed in the Notice of Intended Action.

These amendments are intended to implement Iowa Code chapter 97A.

These amendments will become effective December 1, 2004.

EDITOR'S NOTE: Pursuant to recommendation of the Administrative Rules Review Committee published in the Iowa Administrative Bulletin, September 10, 1986, the text of these amendments [rescind 581—Ch 24; adopt 661—Chs 400 to 404] is being omitted. These amendments are identical to those published under Notice as **ARC 3586B**, IAB 8/18/04.

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[For replacement pages for IAC, see IAC Supplement 10/27/04.]

ARC 3755B

UTILITIES DIVISION[199]

Adopted and Filed

Pursuant to Iowa Code sections 476.1, 476.2, 476.20, and 17A.4, the Utilities Board (Board) gives notice that on October 5, 2004, the Board issued an order in Docket No. RMU-04-5, In re: Revisions to Level Payment Plan Rules [199 IAC 19.4(11) and 20.4(12)], "Order Adopting Rules." The Board is rescinding its current level payment plan rules and adopting new level payment plan rules that provide the utilities the flexibility to develop better level payment plans. The Board is not adopting proposed new paragraphs 19.4(11)"f" and 20.4(12)"f" since similar provisions are in the current rules in paragraphs 19.4(11)"a" and 20.4(12)"a."

A Notice of Intended Action with the proposed rescission and proposed new rules was published in IAB Vol. XXVII, No. 1 (7/7/04) p. 39, as **ARC 3493B**. Comments concerning the proposed amendments were filed by the Consumer Advocate Division of the Department of Justice, Interstate Power and Light Company, Aquila, Inc., d/b/a Aquila Networks, and MidAmerican Energy Company.

An oral presentation was held on September 1, 2004. MidAmerican Energy Company, Interstate Power and Light Company, and the Iowa Electric Cooperative Association appeared and provided oral comments.

The Board's order adopting the amendments can be found on the Board's Web site, www.state.ia.us/iub, or in hard copy in the Board's Record Center, 350 Maple Street, Des Moines, Iowa 50319-0069.

The Board made several revisions to the proposed new level payment plan rules based upon the comments received. These revisions were either to clarify or provide additional flexibility in the rules.

These amendments are intended to implement Iowa Code sections 476.1, 476.2, 476.20, and 17A.4.

The new level payment plan provisions will become effective December 1, 2004.

The following amendments are adopted.

ITEM 1. Rescind paragraph **19.4(11)"e"** and adopt the following **new** paragraph in lieu thereof:

e. Level payment plan. Utilities shall offer a level payment plan to all residential customers or other customers whose consumption is less than 250 ccf per month. A level payment plan should be designed to limit the volatility of a customer's bill and maintain reasonable account balances. The level payment plan shall include at least the following:

(1) Be offered to each eligible customer when the customer initially requests service.

(2) Allow for entry into the level payment plan anytime during the calendar year.

(3) Provide that a customer may request termination of the plan at any time. If the customer's account is in arrears at the time of termination, the balance shall be due and payable at the time of termination. If there is a credit balance, the customer shall be allowed the option of obtaining a refund or applying the credit to future charges. A utility is not required to offer a new level payment plan to a customer for six months after the customer has terminated from a level payment plan.

(4) Use a computation method that produces a reasonable monthly level payment amount, which may take into account forward-looking factors such as fuel price and weather forecasts, and that complies with requirements in 19.4(11)"e"(4). The computation method used by the utility shall be described in the utility's tariff and shall be subject to board approval. The utility shall give notice to customers when it changes the type of computation method in the level payment plan.

The amount to be paid at each billing interval by a customer on a level payment plan shall be computed at the time of entry into the plan and shall be recomputed at least annually. The level payment amount may be recomputed monthly, quarterly, when requested by the customer, or whenever price, consumption, or a combination of factors results in a new estimate differing by 10 percent or more from that in use.

When the level payment amount is recomputed, the level payment plan account balance shall be divided by 12, and the resulting amount shall be added to the estimated monthly level payment amount. Except when a utility has a level payment plan that recomputes the level payment amount monthly, the customer shall be given the option of applying any credit to payments of subsequent months' level payment amounts due or of obtaining a refund of any credit in excess of $25.

Except when a utility has a level payment plan that recomputes the level payment amount monthly, the customer shall be notified of the recomputed payment amount not less than one full billing cycle prior to the date of delinquency for the recomputed payment. The notice may accompany the bill prior to the bill that is affected by the recomputed payment amount.

(5) Irrespective of the account balance, a delinquency in payment shall be subject to the same collection and disconnection procedures as other accounts, with the late payment charge applied to the level payment amount. If the account balance is a credit, the level payment plan may be terminated by the utility after 30 days of delinquency.

ITEM 2. Rescind paragraph **20.4(12)"e"** and adopt the following **new** paragraph in lieu thereof:

e. Level payment plan. Utilities shall offer a level payment plan to all residential customers or other customers whose consumption is less than 3,000 kWh per month. A level payment plan should be designed to limit the volatility of a customer's bill and maintain reasonable account balances. The level payment plan shall include at least the following:

(1) Be offered to each eligible customer when the customer initially requests service.

(2) Allow for entry into the level payment plan anytime during the calendar year.

(3) Provide that a customer may request termination of the plan at any time. If the customer's account is in arrears at the time of termination, the balance shall be due and payable at the time of termination. If there is a credit balance, the customer shall be allowed the option of obtaining a refund or applying the credit to future charges. A utility is not required to offer a new level payment plan to a customer for six months after the customer has terminated from a level payment plan.

(4) Use a computation method that produces a reasonable monthly level payment amount, which may take into account forward-looking factors such as fuel price and weather forecasts, and that complies with requirements in 20.4(12)"e"(4). The computation method used by the utility shall be described in the utility's tariff and shall be subject to board approval. The utility shall give notice to customers when it changes the type of computation method in the level payment plan.

The amount to be paid at each billing interval by a customer on a level payment plan shall be computed at the time of entry into the plan and shall be recomputed at least annually. The level payment amount may be recomputed monthly, quarterly, when requested by the customer, or whenever price, consumption, or a combination of factors results in a new estimate differing by 10 percent or more from that in use.

When the level payment amount is recomputed, the level payment plan account balance shall be divided by 12, and the resulting amount shall be added to the estimated monthly level payment amount. Except when a utility has a level payment plan that recomputes the level payment amount monthly, the customer shall be given the option of applying any credit to payments of subsequent months' level payment amounts due or of obtaining a refund of any credit in excess of $25.

Except when a utility has a level payment plan that recomputes the level payment amount monthly, the customer shall

be notified of the recomputed payment amount not less than one full billing period prior to the date of delinquency for the recomputed payment. The notice may accompany the bill prior to the bill that is affected by the recomputed payment amount.

(5) Irrespective of the account balance, a delinquency in payment shall be subject to the same collection and disconnection procedures as other accounts, with the late payment charge applied to the level payment amount. If the account balance is a credit, the level payment plan may be terminated by the utility after 30 days of delinquency.

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